

**MIDTERM REVIEW OF THE
TANZANIA FAMILY PLANNING SERVICES
SUPPORT (FPSS) PROJECT
(621-0173)**

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ABBREVIATIONS

ACMO/P	Assistant Chief Medical Officer/Prevention
AIDS	Acquired Immunodeficiency Syndrome
AIDSCAP	AIDS Technical Services Project
AMREF	African Medical and Research Foundation
AVSC	Association for Voluntary Surgical Contraception
BOS	Bureau of Statistics
CA	Cooperating Agency
CAFS	Centre for African Family Studies
CBD	Community Based Distribution
CEDPA	Centre for Development and Population Activities
CMBT	Christian Medical Board of Tanzania
CMS	Central Medical Store
CPR	Contraceptive Prevalence Rate
CPSP	Country Program Strategic Plan
CPT	Contraceptive Procurement Table
CTT	Central Training Team
CYP	Couple Years of Protection
DANIDA	Danish International Development Agency
DHS	Demographic and Health Survey
DMO	District Medical Officer
EDP	Essential Drug Program
EPI	Expanded Program of Immunization
EU	European Union
EVALUATION	Evaluation of Family Planning Program Impact Project
FAMPLAN	Computer program for modeling cost and effectiveness of family planning programs
FP	Family Planning
FPLM	Family Planning Logistic Management Project
FPSS	Family Planning Services Support Project
FPU	Family Planning Unit
FY	Fiscal Year
GDP	Gross National Product
GOT	Government of Tanzania
GTZ	German Association for Technical Cooperation
HANDS	Health and Nutrition District Support Project
HED	Health Education Division
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IBRD	International Bank for Reconstruction and Development (World Bank)
IDM	Institute of Development Management
IEC	Information, Education, and Communication
INTRAH	Program for International Training in Health

IPPF	International Planned Parenthood Federation
IPAS	International Projects Assistance Services
IUD	Intrauterine Device
JHPIEGO	Johns Hopkins Program for International Education in Reproductive Health
JHU/PCS	Johns Hopkins University Population Communication Services Project
JOICFP	Japanese Organization for International Cooperation in Family Planning
KAP	Knowledge, Attitudes, and Practices
LOP	Life of Project
LMIS	Logistics Management Information System
LT/P	Long-Term/Permanent Methods
MCH	Maternal and Child Health
MCHA	Maternal and Child Health Aide
MEWATA	Medical Women's Association of Tanzania
MIS	Management Information System
ML/LA	Minilaparotomy Under Local Anesthesia
MOH	Ministry of Health
MTR	Midterm Review
NA	Not Applicable
NACP	National AIDS Control Programme
NAPCO	National Pharmaceutical Company
NFPAC	National Family Planning Advisory Committee
NFPP	National Family Planning Program
NGO	Non-Governmental Organization
NPP	National Population Policy
NSV	No-scalpel Vasectomy
OC	Oral Contraceptive
ODA	Overseas Development Administration (U.K.)
OPTIONS	Options for Population Policy Project
OR	Operations Research
OTTU	Organization of Tanzanian Trade Unions
PACD	Project Assistance Completion Date
PHC	Primary Health Care
POFLEP	Population & Family Life Education Program
POPTECH	Population Technical Assistance Project
PP	Project Paper
PPU	Population Planning Unit
PSI	Population Services International
RAPID	Resources for the Awareness of Population Impact on Development Project
REDSO/ESA	Regional Economic Development Services Office/East and Southern Africa
RMO	Regional Medical Officer
RTT	Regional Training Team
SAS	Situation Analysis Study
SDA	Seventh Day Adventist Church
SDP	Service Delivery Point
SEATS	Family Planning Services Expansion and Technical Support Project
SIDA	Swedish International Development Authority
STD	Sexually Transmitted Disease

TA	Technical Assistance
TAMA	Tanzania Midwifery Association
TAP	Tanzania AIDS Project
TDHS	Tanzanian Demographic and Health Survey
TFR	Total Fertility Rate
TKAPS	Tanzanian Knowledge, Attitudes, and Practices Survey
TOHS	Tanzania Occupational Health Services
TSAS	Tanzania Family Planning Situation Analysis Survey
UMATI	Tanzania Family Planning Association
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission on Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
UWT	Union of Tanzanian Women
VSC	Voluntary Surgical Contraception, Voluntary Safe Contraception

EXECUTIVE SUMMARY

Country Background

The current population of Tanzania is estimated at over 27 million people, growing at the rate of 2.8 percent annually (with a concomitant doubling time of just over 20 years). Approximately 54 percent of the population is under age 15, implying continued high population growth rates and high dependency ratios. In 1992 the average GNP per capita was estimated at \$110, making Tanzania one of the poorest countries in the world. Over 80 percent of the population is employed in the agriculture sector, producing 60 percent of GNP and the bulk of commercial exports. In 1991 under-five mortality was 141/1000 live births, implying that one in seven children died before reaching their fifth birthday.

Over 90 percent of Tanzanians live within five to 10 kilometers of a health facility. Health care services are provided by an extensive government network of hospitals, health centers, and dispensaries. Inadequate training of personnel, unavailability of drugs and equipment, and lack of maintenance have diminished the effectiveness of these facilities. Although the government has made serious efforts to expand the quality and availability of health care services, the lack of resources has resulted in serious constraints in the face of increasing demand for services.

Project Background

The Family Planning Services Support Project (FPSS) was signed August 20, 1990 with a project assistance completion date (PACD) of December 31, 1997 and life of project funding of \$20 million dollars. At Project Paper design, USAID/Tanzania indicated that FPSS is the first phase of an anticipated 15–20 years of USAID population assistance to Tanzania.

The project goal is to improve the health and well being of women and children by enhancing the opportunity to choose freely the number and spacing of children. The project purpose is to increase contraceptive prevalence and use. There are three interrelated project outputs: Output 1: expanded delivery of quality family planning services; Output 2: enhanced Tanzanian institutional capacity; and Output 3: development of an institutional base.

FPSS supports USAID/Tanzania's Country Program Strategic Plan objective of increasing family planning use. The project goal and purpose also parallel the goal of the government's National Family Planning Program to improve the health status of mothers and children.

Project Design

The Project Paper design was undertaken at a time (1990) when there were few accurate statistics to guide the development of the document. Since that time, a number of studies and assessments have been undertaken to provide very good information on the demographic,

health, and health delivery system in the country. A Demographic and Health Survey (DHS) was undertaken in 1991/92, a Situational Analysis in 1992, and a Tanzania Knowledge, Attitudes, and Practices Survey (TKAPS) in 1992 and 1994. Additionally, all the Cooperating Agencies (CAs) providing technical assistance to the project since 1990 have undertaken assessments of their projects. This rich data base will be helpful in developing better indicators of future project progress.

Midterm Review of FPSS

A midterm review team was requested by USAID/Tanzania to 1) document the progress made nationally since the inception of FPSS and its contribution toward institutionalization of family planning services in Tanzania; 2) review the achievement of project objectives as stated in the Project Paper and the logframe; 3) identify gaps under FPSS that need to be filled in the next phase of FPSS or in a new FPSS project; and 4) provide recommendations that will assist USAID/Tanzania in the development of a follow-on project in FY 1997.

Project Management and Implementation

FPSS management and implementation is provided through USAID support directly to the government and through funding of CAs which provide technical assistance to the government and the private sector. The project primarily provides assistance to the Ministry of Health to undertake the National Family Planning Program. The achievements of FPSS, therefore, contribute substantially to the success of the government's program. USAID and UNFPA are the largest donors to the family planning sector with the International Planned Parenthood Federation (IPPF), Overseas Development Assistance (ODA/UK), and German Association for Technical Cooperation (GTZ) providing significant assistance.

Major Findings¹

The project has played a major role in effecting the following achievements since implementation began in 1991:

- Modern method contraceptive prevalence more than doubled (seven percent to 16 percent) in the first half of the project period (1991–1994).
- New acceptors increased 40–50 percent between 1991 and 1994; monthly resupply client visits rose 23 percent.
- By mid-1994, 79 percent of women and 90 percent of men knew at least one modern method of contraception.

¹ Largely based on preliminary and incomplete analysis of the 1994 TKAPS.

- The proportion of facilities offering injectibles, IUDs, and foam has more than doubled, and almost 100 percent of facilities offer oral contraceptives and condoms.
- There was a 46 percent increase in the number of first attendances for family planning services.
- A wide variety of training has been supported, but requirements for additional training present a great challenge.

Conclusions

The Family Planning Services Support Project has made exceptional progress toward reaching the goal and purpose as described in the Project Paper. Through FPSS, USAID/Tanzania works in close partnership with the government, CAs, and other donors and has been a major contributor to this progress. Notable project contributions include solid improvements in contraceptive logistics and availability, strengthening of the Family Planning Unit within the Ministry of Health to its unquestioned leadership of the National Family Planning Programme (NFPP), and flexibility by USAID/Tanzania's management in responding to changing country needs. In order to continue and increase momentum, additional USAID and other resources will be needed through the project completion date.

Major recommendations include the following:

- Provide additional financial resources (\$9 million) to continue progress toward FPSS objectives through the PACD. This includes \$2 million for additional contraceptives.
- Pursue child survival funding to support the project.
- Consider extending the project for two to three years in order to better institutionalize capacity in the public and private sectors.
- Update project indicators to improve the measurement of FPSS outputs.
- Continue to support capacity building at the central level and extend this capacity building down to the regional and district levels.
- Support an assessment of the private sector and develop a strategy/action plan for expanding family planning services in the private sector.
- Increase the range of donors to diversify the funding base and expand the involvement of the private sector for a more sustainable program.
- Develop a national strategy for achieving a sustainable family planning program.
- With other donors, influence the government to allocate a larger share of the national budget to preventive health.

- Work with the IPPF affiliate (UMATI) to identify long-term technical assistance to strengthen program management (for voluntary surgical contraception and NORPLANT[®]) at the central and area office levels.
- Support expansion of long-term and permanent methods.
- Request assignment of a Michigan Population Fellow to assist in developing and managing FPSS activities in the private sector.

SUMMARY OF RECOMMENDATIONS

1. USAID/Tanzania should request that child survival funds be added to the FPSS. (Page 9)
2. If USAID/Tanzania determines that additional safe motherhood interventions (besides family planning) should be integrated into FPSS activity, a safe motherhood assessment should be commissioned to ascertain the most appropriate interventions to add to FPSS activities. (Page 9)
3. USAID should request assignment of a Michigan Population Fellow to explore and assist in managing additional family planning activities for FPSS support in the private sector. (Page 13)
4. Because of FPU's rapid rate of success in management and implementation of the NFPP and its shortage of resources, the FPSS should provide additional funds sufficient to continue current levels of support to the FPU throughout the remaining life of the project. Estimated additional funds required are \$2.4 million. (Page 14)
5. USAID should continue to explore acceptable means to provide FPU continuing, long-term residential or intermittent short-term technical assistance in management throughout the current life of project. (Page 15)
6. The GOT and USAID/Tanzania should become forces in encouraging other donors to support population/family planning activities, thus diversifying the GOT's donor support. (Page 19)
7. USAID should hold or cause to be held quarterly meetings (or every six months) with donors involved with family planning/population activities. This would provide an opportunity for donors to discuss relevant issues and lessons learned within the sector. (Page 19)
8. USAID and UNFPA should reassess the requirements for Depo-Provera and possibly increase procurement to avoid future stock-outs. (Page 23)
9. FPSS should monitor the progress of the UMATI Area Offices in conducting supervision and provide additional assistance if requested. (Page 23)
10. FPSS should continue to support the expansion of LT/P through the project completion date. An additional \$2.0 million will be required to increase VSC and nonsurgical vasectomy sites, train additional providers, and provide supplies/equipment to serve VSC, NSV, NORPLANT[®], and IUD clients. (Page 25)

11. FPSS should work with UMATI to identify the type of long-term TA required to strengthen program management of the program at both the central and area office level. (Possibly a Michigan Fellow). (Page 25)
12. FPSS should support the development of further facility-linked rural, urban, and worksite-based CBD programs with the objective of extending CBD services to underserved rural areas with low CPR. (Page 27)
13. FPSS, NGOs, and FPU should collaborate to develop a standardized and simplified reporting format for contraceptives distributed by CBD agents suitable also as the basis for resupply of commodities to the CBD agents. (Page 28)
14. FPSS, FPU, and NGOs need to develop standardized CBD agent and supervisor training materials and training/retraining courses. (Page 28)
15. FPSS should encourage HED/PCS, SDA, and UMATI to develop appropriate IEC materials for distribution to CBD agents through all CBD programs. (UMATI presently is testing CBD IEC materials designed specifically for use in the Dar es Salaam area.) (Page 28)
16. FPSS should support the acceleration of training for clinical skills for service providers and strengthen the capacity of the Regional Training Teams. (Page 32)
17. There will continue to be a substantial amount of short-term and long-term TA for training required until the end of the project. FPSS, however, should begin with FPU to develop a strategy that identifies how TA will be phased out and how FPU will assume these responsibilities. (Page 33)
18. FPSS should support a workshop of relevant parties to develop an action plan that will expand and update the FP content in the current preservice curricula (Medical, Nursing, and MCH Aide). (Page 33)
19. FPSS should accelerate supervisory training so that the majority of supervisors are trained by December 1995. USAID may wish to engage the services of a management organization for this purpose. (Page 33)
20. Since the creation of a resident advisor position within the HED has been accepted in principle by all of the interested parties (USAID, PCS, and the MOH), a Scope of Work should be developed and recruitment for the position should get under way as soon as possible. (Page 38)
21. The IEC resident advisor should work with the HED and FPU to accelerate the production and facilitate the distribution of IEC materials. (Page 38)

22. The resident advisor and USAID should work to ensure that an IEC/Research Coordinating Committee or IEC Technical Committee is in fact established and holds regular meetings. (Page 38)
23. FPSS should encourage agencies involved in IEC activities, particularly PCS and HED, to work together to expand the use of radio and other nonprint media, including television, videos, film shows, and folk performances. (Page 38)
24. The PCS resident advisor should work with the FPU and other organizations/groups to upgrade and strengthen the FP service provider counseling training curriculum. (Page 39)
25. FPSS should support an assessment of the private sector leading to the development of a short-term to medium-term strategy/action plan for expanding family planning services through private sector channels. (Page 46)
26. Once the strategy/action plan for private sector expansion is developed, FPSS should initiate pilot activities with CMBT (possibly through UMATI), PSI for marketing the oral contraceptive and possibly Depo-Provera, and medical associations. Pilots might also be developed with other targets of opportunity, such as those with UWT. (Page 47)
27. An additional \$2 million must be added to the contraceptive line item of the FPSS budget to assure adequate funding of contraceptive procurement through the PACD. (Page 50)
28. FPSS should procure a 10-ton truck for use in moving contraceptives from the central to regional warehouses and 20 double-cab pickups to support the supervision and contraceptive distribution from the regional level. (Page 51)
29. The FPU should produce a one-page contraceptive stock situation report quarterly. This report should be shared with donors. (Page 51)
30. During mid-1995, USAID and the FPU should review IDM's capacity for assuming full responsibility for the remaining logistics training activities. (Page 52)
31. FPU should develop a manual and curriculum for a service delivery information system. Study tours should be conducted to Ghana and Botswana in support of this activity. (Page 55)
32. A service delivery MIS component should be appended to the IDM/FPLM logistics training curriculum. (Page 55)

33. The FPU should actively participate in and support the implementation of the new commodities/logistics reporting system and HMIS in order to expedite their full implementation. Until a reliable routine system is in place, the ability of the FPU and USAID to track program outputs on a timely basis will remain limited. (Page 59)
34. Operations research in support of program expansion should be activated as soon as possible, making sure that FPU and MOH staff members are active participants in such studies to ensure that study findings are incorporated into subsequent program decision making. (Page 59)
35. Further initiatives to improve the utilization of data for program monitoring should focus on the field level, because data use at this level is likely to have the most immediate payoff in terms of improved service delivery. Should USAID decide to support further interventions in improving program supervision, part of any such initiatives should be the use of routine service statistics at the SDP and district levels. (Page 59)
36. USAID should schedule another round of evaluations and/or assessments for program activity areas, such as those undertaken prior to the MTR, to be available for the final project evaluation. These data, when used in combination with data from the series of large-scale surveys, should provide a rich data basis for the design of a follow-on project. (Page 59)
37. Another Situation Analysis Study should be conducted at about the same time as the next full-scale DHS in order to provide detailed information on the nature and magnitude of improvements in service delivery system functioning. In order to be of maximum utility for program evaluation purposes, the SAS should be undertaken in the same sample areas/clusters as the DHS. (Page 60)
38. FPU and USAID should encourage, facilitate, and, as feasible, participate in secondary analyses of the TDHS and TKAPS on topics relevant to NFPP program functioning and strategic planning. (Page 60)
39. USAID and FPU should integrate appropriate IEC and service interventions targeting youth into the FPSS program. Training to improve the attitudes and practices of service providers toward youth should be a particular emphasis. (Page 61)
40. FPU and USAID (Health, Population, and Nutrition, and TAP staff) should meet to review where STD/HIV education and service provision should be strengthened within The FPSS Project. (Page 62)
41. USAID and FPU should commission an assessment by the International Projects Assistance Services (IPAS) that would look at the need for training and equipping providers to safely treat complications from abortion and providing post-abortion counseling and family planning services. If it is determined that

need exists, the assessment should be followed by an action plan and the appropriate interventions. (Page 62)

42. USAID should provide technical assistance to FPU to utilize The RAPID Project to raise awareness related to the high mortality and morbidity due to abortion (and adolescent fertility). (Page 63)
43. USAID (in cooperation with UNHCR) should follow the refugee situation and work with FPU and UMATI to provide contraceptives (and condoms for HIV protection) if the need arises. (Page 63)
44. FPSS should continue to support capacity building at the central level in family planning program management, service provision, IEC, and logistics and work to extend this capacity building down to the regional and district levels (Page 67)
45. FPSS should support an assessment of the various options for sustainability and a workshop for development of a national strategy for achieving a sustainable family planning program. This activity could be handled through a buy-in to The OPTIONS Project for approximately \$100,000. (Page 68)
46. USAID/Tanzania should work with other major donors to the health sector to develop a strategy to convince the government of the need to allocate a larger share of health funding for preventive services. (Page 68)
47. The FPU and USAID/Tanzania should work to diversify the funding base for the NFPP and in particular, increase the range of donors so that the public sector program is not overly dependent on one or two major donors, as is currently the case, and expand the involvement of the private sector. (Page 68)
48. FPSS should support the steps to institutionalize preservice training to ensure that an established structure exists to train high-quality health providers from the onset (instead of relying only on in-service training). (Page 68)

1. INTRODUCTION

1.1 Social, Cultural, and Economic Context

The social, cultural, and economic landscape of Tanzania is characterized by diversity and heterogeneity. There are many indigenous ethnic groups and enormous ecological and agricultural variations across the 900,000 square kilometers. The poor condition of the infrastructure hampers communication and transportation and creates uneven availability of and access to goods and services, including health services.

The current population of Tanzania is estimated at over 26 million people, of which over 1.5 million live in the capital and principal city, Dar es Salaam. High densities of rural population are found in the highland areas of both northern and southern Tanzania and along the southern shores of Lake Victoria. The population is also quite mobile. People move readily from one rural area to another, or to urban areas, in search of employment. Short-term, seasonal migration by agricultural workers alone involves the movement of over one million individuals every year.

Agriculture is the mainstay of the Tanzanian economy. Over 80 percent of the economically active population is employed in agriculture, producing over 60 percent of GNP and the bulk of commercial exports. Most farms are less than two hectares in size, and farmers employ simple, primarily manual, technology. Many farming households diversify their income sources by operating small enterprises and seeking wage labor to complement their agricultural activities. Production of basic food crops for on-farm consumption and for sale is dominant. The traditional export cash crops, such as coffee and tea, account for only eight percent of agricultural GNP.

Average GNP per capita for Tanzania in 1992 was estimated at \$110, making Tanzania one of the poorest countries in the world. There are, however, indications that the official GNP statistics do not provide a complete picture of economic activity. Informal sector employment engages about 22 percent of the total workforce, 15 percent in rural areas and 56 percent in urban areas. The estimated gross output of the informal sector in 1991 exceeded that of the parastatal sector and was equivalent to more than 30 percent of official GNP.

Social identity and position and legal status in Tanzania vary by age and gender, with advantages accruing to older males. Despite recent advances, women's ability to negotiate is restricted by both the law and customary regulations, which has implications for their participation in decision making, including decisions about their own reproductive behavior.

Tanzania's institutional capacity, particularly in the education, health, and social services sectors, is under serious stress. Although the government of Tanzania (GOT) has made serious efforts to expand the quality and availability of health care services, both facilities and personnel are simply inadequate to meet continually increasing demand. The development of an extensive network of facilities has made health care more widely available in theory, but the effectiveness of these facilities is diminished by shortages and inadequate training of personnel, the virtually constant unavailability of many important drugs, and the inaccessibility of service delivery points to a small but significant proportion of the rural population. The

private sector also provides considerable health care resources in the forms of facilities, personnel, and training, but, in the absence of donor assistance, the total of private and public interventions falls short of what is needed to make substantive improvements in the current health situation.

1.2 Project Description

The Family Planning Services Support Project (FPSS) was signed August 20, 1990, with a project assistance completion date (PACD) of December 31, 1997, and life of project (LOP) funding at \$20 million. It is USAID/Tanzania's first bilateral population activity and followed several years of active involvement by Cooperating Agencies (CAs) using central funds. At the time of the Project Paper (PP) design, USAID indicated that this seven-year project is the first phase in an anticipated 15–20 years of USAID population assistance to Tanzania.

The project goal is to **improve the health and well-being of women and children by enhancing the opportunities to choose freely the number and spacing of children**. The project purpose is to **increase contraceptive prevalence and use**. There are three interrelated project outputs addressing the constraints identified as inhibiting increased use of family planning (FP). Output 1: expanded delivery of quality clinical FP services. This incorporated anticipated actions dealing with contraceptive supply and logistics, training and motivation, contraceptive method mix, and private sector and nongovernmental organization (NGO) clinical services. Output 2: enhanced Tanzanian institutional capacity. When achieved, the output would improve performance by the Ministry of Health (MOH), the Tanzanian Family Planning Association (UMATI), and agencies concerned with information, education, and communication (IEC). Output 3: development of an information base with activities in national information-gathering and analysis, development of a management information system, and operations research.

1.3 Scope of Work

The midterm review (MTR) team was asked to document the progress made nationally since the inception of FPSS and especially its contribution toward institutionalization of FP services in Tanzania; review the achievement of project objectives; identify gaps under the FPSS that need to be filled in the next phase of the FPSS or in a new FPSS project; and provide recommendations that will assist USAID/Tanzania in the development of a follow-on project potentially to be designed in FY 1997. By responding to a series of specific questions, the team was asked to identify activities or components which could make FPSS assistance more effective through changes in the emphasis accorded each or through qualitative or quantitative changes, and to indicate whether suggested project changes would require different levels of funding or an extension in the PACD. The entire Scope of Work and list of team members appears in Appendix A.

1.4 Evaluation Methodology

USAID/Tanzania assembled a multidisciplinary team provided by the centrally-funded POPTECH and EVALUATION Projects, personnel from USAID/Washington, REDSO/ESA, USAID/Nigeria and USAID/Tanzania (the evaluation officer), and African professionals from UMATI, MOH, the University of Dar es Salaam, the Muhimbili University College of Health Sciences, and independent consultants. USAID/Tanzania professional staff members from the Office of Population and Health organized and facilitated the evaluation and served as resource persons.

Team members were provided project and briefing documents in advance. The US-based evaluators were assembled in Washington, provided additional reading materials, and briefed by personnel familiar with the Tanzanian National Family Planning Programme (NFPP) and the FPSS. The entire team assembled in Dar es Salaam and began a series of briefings and team meetings on September 19, 1994, starting with the Mission with full participation by the USAID Director. The team then embarked on a series of individual and group meetings with GOT organizations including the Family Planning Unit (FPU), the Health Education Division (HED), the Bureau of Statistics (BOS), UMATI, NGOs, other donors, and appropriate USAID personnel. Although the MTR team was large (12 evaluators and 3 USAID resource professionals), team coordination was afforded by regular morning MTR team/USAID meetings. A tentative outline for the evaluation report was developed during the first few days and modified periodically throughout the assignment. Drafting responsibilities were assigned and periodically modified as well. A week into the visit (September 25–28), portions of the Team, accompanied by USAID personnel, made brief field visits to Arusha/Kilimanjaro, Mwanza, and Morogoro Regions to observe FPSS and other population/family planning activities. Wherever possible, primary data sources were identified, analyzed, and used.

The team reassembled in Dar es Salaam, additional visits were scheduled and the report redrafted after discussions. A preliminary debriefing was held with USAID personnel, including the Mission Director, on September 30 and with USAID, GOT organizations, and other donors on October 4. Graphs and figures mostly comparing results of the 1991–92 Tanzania Demographic and Health Survey (TDHS) and preliminary results of the 1994 Tanzania knowledge, attitudes, and practices survey (TKAPS) were presented and are included in Appendix E. Revisions were made in response to comments. The final report was prepared by the team leader and the Population Technical Assistance Project in collaboration with USAID.

Although USAID personnel were responsive at all times to requests for information and support, they encouraged team members to meet individuals or groups independently and unaccompanied as desired.

Appendix B lists persons interviewed and Appendix C lists the documents reviewed.

2. PROJECT ACCOMPLISHMENTS

2.1 Project Purpose and Outputs

The purpose and planned outputs of The FPSS Project as stated in the PP, as well as indicators and accomplishments to date, are summarized in Tables 2.1 and 2.2 (pages 70 and 71).

As may be seen from Table 2.1, the target set for contraceptive prevalence has been exceeded in the first three years of the project. The project target for increase in acceptors returning for resupply has nearly been attained during the same period. No baseline figure was available during project design for the target concerning Tanzanian knowledge of one modern contraceptive method. A 1991 knowledge, attitudes, and practices (KAP) survey used as a baseline showed that more than two-thirds of adult Tanzanians already spontaneously knew of one modern method as project implementation began. The magnitude of this indicator in the Project Paper, therefore, is inappropriate and should be revised.

Significant progress has also been made toward the accomplishment of each of three planned project outputs (see Table 2.2), although further effort and additional resources are needed in order to fully accomplish the intended outputs and consolidate the gains made to date. Assessments of performance to date for the major project components and the major constraints faced in each are provided in subsequent sections of this report, along with recommendations for USAID/Tanzania actions that will facilitate the accomplishment of planned project outputs.

2.2 Synthesis of MTR Findings

From virtually all indications in the data available to the MTR team, including preliminary and incomplete analysis of 1994 TKAPS data, the NFPP and The FPSS Project have made an impressive start as indicated by the following:

- Modern method contraceptive prevalence more than doubled in the first half of the project period (seven percent to 16 percent), far exceeding design expectations.
- Utilization of services has grown markedly since project start-up, with MOH/FPU service statistics showing a 46 percent increase between 1992 and 1993 in number of first attendances.
- There has been a sizeable increase since 1991 in the proportion of facilities offering injectibles, intrauterine devices (IUDs), and foam, and almost 100 percent of facilities now offer oral contraceptives and condoms.

- Significant progress has been made in satisfying the unmet need for family planning services that existed at the outset of the project, with 46 percent of total demand being met as of mid-1994.

The demand exists for further project success. TDHS and TKAPS data indicate that total demand for family planning services at the national level grew by 22 percent between 1991 and 1994; levels of exposure to family planning messages and awareness of contraceptive methods are relatively high; and intentions to contracept in the future suggest the likelihood of future growth in demand for services.

Although the contribution of The FPSS Project to NFPP success cannot be measured in exact terms, it is clear to the MTR team that the project has played a major role in effecting these outcomes. Appendix D provides the MTR team's observations on changes in selected aspects of service delivery as well as on selected population-based outcome measures. The data supporting these observations are derived from the population-based surveys that have been undertaken in the project and, to a limited extent, service statistics. They are summarized in Tables 2.2 to 2.6 (pages 71-79).

3. STRATEGIES AND POLICIES

3.1 USAID/Tanzania

3.1.1 *The Country Program Strategic Plan*

Within the USAID/Tanzania Country Program Strategic Plan (CPSP), Strategic Objective No. 3 relates to the health, population, and nutrition sector: **increased use of family planning and HIV/AIDS preventive measures through increased knowledge of and access to family planning information and services.** Measurement of the CPR (contraceptive prevalence rate) (modern methods) is the main indicator to measure the family planning side of the Strategic Objective; increased knowledge of modern contraception and an increase in family planning service delivery sites are the indicators for the target.

3.1.2 *FPSS Linkages to the CPSP*

The FPSS purpose to increase contraceptive prevalence and use is parallel to the CPSP's Strategic Objective to increase use of family planning and HIV/AIDS prevention measures. However, there are a number of factors which may warrant some amendments to the original Project Paper that would improve the measurement of reaching the CPSP target and the FPSS outputs (As discussed in Chapter 15.)

3.2 Government of Tanzania

3.2.1 *National Population Policy*

In 1992, Tanzania enacted its National Population Policy (NPP), confirming the government's commitment to family planning. The NPP covers a wide array of topics ranging from population and the environment to the relationship between family planning and infant and maternal mortality. **The main intention of the NPP is to strengthen FP services, promote the health and welfare of families, and eventually reduce population growth.** The major target of the policy is to reduce the total fertility rate (TFR) from 6.3 (as measured in the 1991 TDHS) to three by the year 2000.

3.2.2 *National Family Planning Program*

The National Family Planning Program goal is **the promotion and protection of the health and nutritional status of the family, especially mothers and children.** Family planning is viewed as an integral component of the maternal and child health (MCH)/FP Program. "It is in an environment of high maternal, perinatal and child mortality and morbidity that the GOT's efforts to promote family planning must be seen. The MOH regards family planning as an

important and effective intervention of protecting the family and promoting good health of mothers and children."

The principal target of the NFPP is to increase the total CPR to 25 percent by 1999 (from an estimated seven percent in 1989). A Plan of Operation was developed for the period of 1989–1993. In 1990 the Ministry of Health established the Family Planning Unit to coordinate and implement the NFPP. The FPU developed a follow-on Strategic Plan to the Plan of Operations for the period of 1994–1999. This plan was approved by the MOH in September 1994.

The Strategic Plan includes the following elements: creating demand for family planning services, expansion of service delivery to meet demand, institutional capacity building of the public and private sectors, and resource development for the program.

3.2.3 FPSS Linkages to the NFPP

The goal of both the FPSS and the NFPP is to improve the health of women and children through increasing the use of family planning services. The FPSS outputs also parallel the NFPP Plan of Operations and Strategic Plan. The principal difference lies in the FPSS's anticipated rise in CPR of modern methods one percent annually as compared to the government's target of 25 percent by 1999.

The NFPP and the USAID/Tanzania CPSP identify child spacing as an area critical to improving child survival in Tanzania. Child spacing has been the least developed of the MCH service delivery components and one of the most critical, given its importance in improving the health status of mothers and children, decreasing the incidence of high-risk births, and reducing infant mortality due to births that are too frequent or too closely spaced.

While there is strong support for other child survival interventions, only USAID and the United Nations Population Fund (UNFPA) provide significant support to child spacing. FPSS represents a flexible mechanism for programming in almost every area of child spacing and reproductive health. FPSS should use child survival funding to improve child spacing.

In addition to child survival, safe motherhood is also considered a critical issue in Tanzania. As has been outlined previously, the NFPP, CPSP and FPSS all recognize the effect of family planning on saving the lives of mothers. Family planning is an important intervention to save maternal lives. It averts unwanted births and all of the complications that lead to maternal death. Other safe motherhood interventions could be added to FPSS; before this is done, however, an assessment by a safe motherhood expert(s) should be undertaken. A USAID Cooperating Agency, such as MotherCare, could be commissioned to undertake an assessment and determine the most productive interventions for The FPSS Project.

3.3 USAID/Washington

The Office of Population has broadened its reproductive health mandate to include the linkage/integration of family planning with sexually transmitted disease (STD)/HIV, post-abortion care, and adolescent reproductive health interventions.

The FPSS Project Paper, written prior to these programmatic initiatives, does not directly address these areas of reproductive health as part of the project's mandate. The objectives of these initiatives, however, clearly fall under the FPSS goal and the USAID/Tanzania's Strategic Objective to enhance changes in reproductive health behavior. These issues, their relationship to FPSS, and recommendations are discussed in Chapter 13, Special Issues.

- 1. Recommendation:** **USAID/Tanzania should request that child survival funds be added to the FPSS.**

- 2. Recommendation:** **If USAID/Tanzania determines that additional safe motherhood interventions (besides family planning) should be integrated into FPSS activity, a safe motherhood assessment should be commissioned to ascertain the most appropriate interventions to add to FPSS activities.**

4. MANAGEMENT

4.1 Institutional Framework

Policies guiding the implementation of the NFPP are the responsibility of the Population Planning Unit (PPU) of the Planning Commission located within the President's Office. The PPU also coordinates the integration of population issues into developmental planning.

The MOH is responsible for family planning services which are administered through the FPU within the MCH/FP Unit of the Department of Preventive Services. The Department is responsible to the Assistant Chief Medical Officer/Prevention (ACMO/P). FPU coordinates family planning activities of governmental agencies, parastatals, universities, UMATI and other NGOs, the private sector, and bilateral and multilateral assistance agencies. Because of a GOT policy of decentralization, the majority of family planning services provided by the public sector are not the direct responsibility of the MOH or FPU, but are delivered through 20 Regional Health Teams and 106 District Health Teams administered by the Ministry of Local Government. Regional and district MCH/FP coordinators are responsible to the regional and district medical officers (RMO, DMO respectively) for supervising FP (and all other MCH) services delivered in approximately 3000 hospitals, health centers, and dispensaries, as well as through community-based services.

The MOH divides the 20 regions into seven zones for MCH/FP administrative purposes and zonal MCH coordinators provide additional supervision and oversight. Because of this division of responsibility between the line ministries and the field, FPU has been dependent on convincing the regional and district medical officers and MCH coordinators to assume a proactive FP role and inducing these authorities to collaborate in management, training, contraceptive logistics, and other FP responsibilities. The FPU's success in establishing these vital relationships has been quite good and will be discussed in various sections throughout this report.

An important component of FPSS is implemented through another unit under the aegis of the ACMO/P, namely IEC implemented through the HED. FPU collaborates with the unit regarding IEC content. Similarly, UMATI manages voluntary surgical contraception (VSC) on behalf of FPU.

4.2 USAID Management of the FPSS

Mission management of the FPSS is vested in one USAID direct-hire population and health officer, a senior population program specialist on a personal services contract, and a Tanzanian population program assistant. FPSS management requires frequent contacts/negotiations with FPU, HED, UMATI and other NGOs, regional and district health and family planning units, existing and potential bilateral and international donors, the University of Dar es Salaam, and CAs involved with implementation.

The CAs involved in the FPSS include the Association for Voluntary Safe Contraception (AVSC) for long-term and permanent methods, including VSC. Macro International assisted with the Tanzania Demographic and Health Survey (TDHS 1991/92), a Tanzania knowledge, attitudes, and practices survey (1994 TKAPS), and later will assist with another TDHS. The Program for International Training in Health (INTRAH) has developed training strategies and capacity, and Johns Hopkins University Population Communications Services (JHU/PCS) is expanding IEC services and capacity. Pathfinder International is developing community-based and workplace FP services, and The Family Planning Logistics Management Project (FPLM) provides logistics management support. For three years ending in June 1994, The Family Planning Services Expansion and Technical Support Project (SEATS) provided management support to the FPU and procured technical services, training, and equipment, including 26 vehicles, for the FPU.

The Mission also utilized USAID centrally-funded resources to support activities. The Evaluation of Family Planning Program Impact (EVALUATION) Project provides technical assistance in evaluation, data gathering, and monitoring to USAID, FPU, and the Bureau of Statistics. Since 1992, The Resources for the Awareness of Population Impact on Development (RAPID) IV Project has trained FPU, PPU, and UMATI personnel in presentations based on the 1991/92 TDHS and other national data. The presentations are likely to be modified or customized using additional data for national, regional, and district level presentations. The Africa Operations Research Project of The Population Council provided technical assistance to the 1992 Tanzania FP Situation Analysis Survey (TSAS) and may be called on for additional activities.

The USAID population staff has coordinated the activities of the multiple project-related CAs tightly resulting in the CAs having separate, but complementary, assignments. There is apparent good collaboration between the CAs and the GOT largely because of the Mission management style. There is obvious professional respect accorded to the Mission population assistance team by USAID colleagues, GOT counterparts and field personnel, NGOs, and all the donors which the MTR team encountered. Special commendation should be given for the managerial collaboration in assessment of need, planning, and division of resource provision between USAID and UNFPA. Examples include USAID and UNFPA providing complementary support to expanding the capabilities of the FPU, identifying cost-effective trade-offs for contraceptive procurement provided by each, and USAID's responding to a need identified by UNFPA (management needs assessment of the FPU). The collaboration between these two organizations in Tanzania is based on frequent, totally open communications and could serve as a model elsewhere.

The USAID/Tanzania Population and Health Office has managed The FPSS Project well. It used SEATS to assist the FPU managerially at project start-up, filled a requirement for paramedical training technical assistance quickly with INTRAH, and has done well in identifying centrally-funded resources for complementing FPSS assistance. In an example of good management, USAID/Tanzania responded to a UNFPA recommendation for a management needs assessment of the FPU that provided information useful to the FPU, UNFPA, and the Mission. Contraceptive logistics have improved immeasurably not only because of FPU and the donors cooperating closely in projecting needs and sharing procurement, but also by a distribution system with FPSS-procured vehicles that shares cost with units distributing

medications and supplies of the Essential Drug Program (EDP) and the Expanded Program of Immunization (EPI). Procurement of equipment and supplies, as called for in the Project Paper, is completed.²

Because activities are moving more rapidly than planned in many areas of the public sector, it may well be time for the project to turn more attention to exploring additional avenues of private sector involvement in FP efforts. Discussions of the private sector are found in Chapter 9. The USAID/Tanzania population office would need additional full-time assistance to fully explore and manage additional private sector activities and focus on other targets of opportunity.

3. Recommendation: USAID should request assignment of a Michigan Population Fellow to explore and assist in managing additional family planning activities for FPSS support in the private sector.

4.3 FPU in Management of the NFPP

When FPSS was signed in 1990, the FPU was comprised of a family planning manager, three professional staff persons, and a sprinkling of support staff. FPSS project design provided funding for additional staff positions in management, training, data entry, and logistics coordination. Because of FPU's relatively new presence within the MOH structure and the sense that absorptive capacity would be limited, the project design team expected that institutional development of the unit would be a long, slow process. Start-up management technical assistance was provided by FPSS through SEATS, which provided 56 person-months of needed assistance including a resident advisor. Activities included procurement, developing the first annual FPU work plan and the strategic planning exercise for the five-year (1994–1999) NFPP Strategic Plan, and arranging short-term management training and observational visits for 63 NFPP personnel. Fortnightly staff, quarterly program review, and annual FPU planning meetings were established, job descriptions adopted, and mechanisms for FPU to coordinate the activities of donors initiated. FPU helped establish and became the secretariat for the National Family Planning Advisory Committee (NFPAC) comprising the national governmental and nongovernmental agencies involved in implementing the NFPP.

At the time of this MTR, the FPU staff totaled 37, including 18 managerial, professional, and technical staff persons, nine of whom are funded through the FPSS. A few indications of FPU's increasingly important role in the NFPP have been its active participation in the formulation of the NPP, development of policy guidelines and standards for family planning service delivery and training, decentralization of paramedical training, and participation in

²As projected in the PP, the following procurement has been completed: 20 double cab pick-ups, two 10-ton trucks, 10 station wagons, four desk-top computers, printers, and two laptop computers, two buses, telephone, telex, and fax equipment of the FPU, televisions, video machines, overhead and slide projectors for the 20 regions, file cabinets, and an examination table.

evaluations/assessments of FPSS and other donor-assisted activities. FPU played a key role in the development of the 1994–1999 NFPP Strategic Plan. The FPU is intimately involved in the management and implementation of nearly every facet of the NFPP.

A measure of the increase in absorptive capacity of the FPU is seen through its ability to administer and utilize project-provided funds for FPSS activities. Only 76 percent of the \$307,000 FPSS provided for activities of the first (1992) work plan were expended, even when the period of implementation was extended by six months. The following year, FPU's managerial capacity had increased and virtually all of the \$440,000 provided was disbursed according to plan. The approved work plan for the year beginning July 1994 has been funded at more than double the previous year at \$991,617. These funds will be disbursed to cover work plan training activities; community based distribution (CBD); service delivery; a management information system; monitoring, research, and evaluation; logistics; and administration costs.

Because of the unexpectedly rapid growth in FPU capabilities and absorptive capacity, FPSS already has committed more funds to the FPU than were anticipated throughout the LOP. After June 1995, no project funds are available to continue FPSS's partial support of the FPU. No additional funding from the GOT or other donors has yet been identified.

4. Recommendation: **Because of FPU's rapid rate of success in management and implementation of the NFPP and its shortage of resources, the FPSS should provide additional funds sufficient to continue current levels of support to the FPU throughout the remaining life of the project. Estimated additional funds required are \$2.4 million.**

In a time of GOT structural readjustment resulting from severe economic hardships concurrent with large increases in family planning requirements and activities, managerial challenges are daunting. FPU cannot continue to use its personnel for implementation of such functions as planning, training, supervision and monitoring, particularly in the decentralized regions and districts, but must continue to find innovative ways (without line authority) to marshal decentralized resources for development of regional and district management and training teams. As the NFPP grows, so will the requirements for liaison with national public and private sector agencies and bodies as well as with international donors and NGOs. Although FPU recently was audited by the GOT Controller and Auditor General with no major deficiencies noted, financial management has required significant external assistance.

In 1993, USAID sponsored a management needs assessment of FPU which recommended continuing FPSS support for residential technical assistance in management throughout the LOP and discussed several mechanisms for providing it. The MTR team is convinced that the FPU has benefited significantly from the residential management assistance heretofore provided by SEATS and intermittent assistance from other sources. The FPU collectively resists the concept of residential managerial assistance while admitting individually to having

grown greatly in management skills during the period of intensive technical assistance (TA). The ACMO/P considers any assistance beyond six months long term. There is no doubt that FPU management capabilities have greatly increased, yet the MTR team is concerned whether FPU has the managerial depth to deal with the burgeoning future managerial demands it faces without additional TA. Specific areas to be emphasized include strategic planning, supervision, monitoring, evaluation, and private sector coordination. An additional need is to influence the FPU to develop and implement strategies to strengthen decentralized regional and district management capabilities. Residential TA is highly desirable for continuity as well as the invaluable opportunities it affords for on-the-spot assistance in problem solving, on-the-job training, and designing short training courses tailor-made to respond to FPU requests.

- 5. Recommendation:** **USAID should continue to explore acceptable means to provide FPU continuing, long-term residential or intermittent short-term technical assistance in management throughout the current life of project.**

5. OTHER DONOR INVOLVEMENT

The major donors to the family planning/population field in Tanzania are USAID, UNFPA, and the International Planned Parenthood Federation (IPPF). The Overseas Development Administration (ODA) and the German Association for Technical Cooperation (GTZ) also make major contributions. USAID/Tanzania has excellent relationships with its in-country donor counterparts. Collaboration with UNFPA, IPPF, ODA, and GTZ has produced very positive results and avoided duplication and infighting which sometimes occurs in other countries. This type of collaboration should expand to include other donors which have the potential to provide expertise and resources to the family planning/population field in Tanzania.

5.1 UNFPA

The UNFPA's current (third) five-year program at \$21 million is the largest UNFPA program in sub-Saharan Africa. This program aims to assist the GOT to attain its development and population goals. Activities of UNFPA include support to family planning and MCH services; IEC; data collection and analysis; population policy formation; population dynamics; and women, population, and development activities. With support from Norway (\$0.7 million), UNFPA is establishing a family planning "model clinic" for training purposes at Muhimbili Medical Centre, which will also house the FPU.

The UNFPA supports FPU staff as well as a significant proportion of national contraceptive needs including Depo-Provera, oral contraceptives, condoms, and intrauterine devices (IUDs). In the future, UNFPA will assume full responsibility for the purchase of condoms. It also purchases equipment and provides short-term training for FPU staff.

5.2 IPPF

The IPPF supports the local affiliate, UMATI (approximately \$1.6 million in 1993). UMATI's strategies include increasing CPR through the provision of accessible, quality family planning services, employing effective IEC interventions, strengthening training capabilities, utilizing resources effectively, and diversifying UMATI's funding base. Pathfinder, AVSC (both with USAID support), the Swedish International Development Authority (SIDA), and Japan will also support UMATI activities in 1994.

5.3 World Bank

The International Bank for Reconstruction and Development (World Bank) is primarily supporting broad public health, curative services, and policy development. Workshops and conferences related to population policy have been supported through the PPU. In the next

two to three years, a new AIDS/Public Health Project (\$50–70 million) is being proposed to support preventive health services including family planning.

5.4 European Union

The European Union (EU) has not been involved with population/family planning activities in Tanzania to date. Typically, it supports major reforms in the health sector. Although it is interested in including family planning/population in its next five-year plan, the EU does not have strong capacity to implement health projects that require strong technical support. Funding could be provided to the GOT or through a multilateral organization (e.g., UNFPA) or a European NGO which can provide the necessary technical assistance.

5.5 Overseas Development Administration

ODA is currently supporting one-third of the Depo-Provera supplies for the country (\$1.4 million in 1994). The recently initiated Family Health Project (\$12.8 million) will focus on family planning and STDs in four districts of Mbeya. The Health and Nutrition District Support Project (HANDS) in Mbeya Urban District (\$0.95 million) works with communities to improve health facility structures and services (including family planning). ODA is also supporting AVSC to establish VSC services at the Mbeya district hospital.

5.6 German Association for Technical Cooperation

GTZ's Family Health Programme aims to strengthen primary health care in eight districts with emphasis on family planning and safe motherhood. The project is implemented through district health management teams and the major components include facilities renovation, medical equipment, training, vehicles, and counseling. The total budget for 1989–94 is \$16.4 million.

5.7 Japanese Organization for International Cooperation in Family Planning

The Japanese Organization for International Cooperation in Family Planning (JOICFP) supports UMATI's community-based family planning project in Kilimanjaro and Morogoro Regions (\$55,000 in 1994). The project increases contraceptive prevalence through its 200 CBD workers who deliver family planning services.

5.8 Other Donor Activity

Strong donor support in the health sector assists to strengthen family planning services directly or indirectly. The Danish International Development Agency (DANIDA) has supported implementation of the Health Information System (HIS), coordinating with FPLM on the family

planning logistics component. DANIDA, the World Bank, and others are providing essential drugs and rehabilitation and equipment facilities. DANIDA, the United Nations Children's Fund (UNICEF) and other donors support health education (which includes family planning) and primary health care transport. The Royal Netherlands Embassy plans to support the procurement of condoms for the AIDS social marketing project.

Utilizing RAPID and the recent TKAPS results, FPU could demonstrate to donors the need for further support within the population/family planning sector. Similarly, USAID could assess the possibility of collaboration with the EU and the World Bank.

5.9 Recommendations

- 6. Recommendations:** **The GOT and USAID/Tanzania should become forces in encouraging other donors to support population/family planning activities, thus diversifying the GOT's donor support.**
- 7. Recommendation:** **USAID should hold or encourage quarterly (or every six months) meetings of donors involved with family planning/population activities. This would provide an opportunity for donors to discuss relevant issues and lessons learned within the sector.**

6. SERVICE DELIVERY

6.1 Clinical Services

6.1.1 Background

For the purpose of this report, service delivery will include progress toward contraceptive prevalence, method mix, availability of facilities, distribution of contraceptives, and service volume. Training, IEC, and contraceptive logistics will be discussed in subsequent sections. At the outset of FPSS, over 70 percent of FP services were provided by the MOH (1991/92 TDHS), while the remainder was supplied by NGOs and parastatals. The 1993 Tanzania Health Status Abstract indicated that MOH outlets included 174 hospitals, 176 health centers, and 3,014 dispensaries.

The 1991 TDHS indicated that the CPR was 10 percent for all methods with 6.6 percent for modern methods. This CPR reflected a skewed method mix with 52 percent of acceptors using oral contraceptives, 25 percent using VSC, 11 percent using condoms, six percent using IUDs, and six percent using injectables.

Although physical access to a health facility was not a problem (in 1991, the mean distance to a hospital was nine kilometers, health clinic was eight kilometers, and dispensary was four kilometers); access to adequate family planning services and supplies was more difficult. Very few facilities offered FP services and even fewer had contraceptive supplies. The 1991/92 service availability module of the TDHS indicated that 37 percent of health centers provided injectables but only 30 percent had stock; and 14 percent of dispensaries offered services but only 12 percent had supplies.

At the beginning of FPSS, Tanzania had a total family planning demand of 41 percent, while unmet demand accounted for 30 percent (12 percent limiters and 18 percent spacers). The 1991/92 TDHS confirmed the assumptions of the FPSS project design that the low contraceptive prevalence rate resulted from an inadequate supply environment.

6.1.2 Achievements

Rise in CPR. The 1994 TKAPS indicates that CPR has risen to 24 percent for all methods with 16 percent modern methods (see Table 2.6, page 80). These data suggest that the NFPP has made great strides in the expansion and improvement of FP services. This rise in CPR is the result of many groups including the MOH, NGOs, and other donors, with FPSS being a major player.

FPSS had a modest objective to increase CPR for modern methods by one percent annually, which, if achieved, would yield a CPR for modern methods of 14 percent by 1997. This target had been exceeded by mid-1994.

Improvements in service delivery. Progress to date is reflected by the increase in the numbers of facilities offering FP services, demonstrated improvements in commodities distribution, and substantial increases in service volume. In the 1994 TKAPS, the number of health centers and dispensaries providing injectables has risen to 91 percent (from 37 percent) and 84 percent (from 14 percent), respectively. In addition, 90 percent of health centers had injectables in stock while 84 percent of dispensaries also had supplies. These improvements were also observed with other methods (see Table 2.3, page 74). Data from several sources indicate that the numbers of acceptors being served rose between 40 percent and 50 percent in the project period to date which is consistent with the rise in CPR. FPSS has contributed to this effort through training of service providers and procurement and provision of contraceptives. Both hospitals and health centers showed significant increases in mean numbers of new acceptors and resupply clients served per facility, while dispensaries, the closest facility for most people, showed little change between 1991 and 1994. This may indicate that dispensaries have not benefited from training and logistical improvements to the extent that hospitals and health centers have.

Method mix. Although there are many more users of modern methods in 1994, there has been little significant overall change in the method mix in terms of long-term versus short-term methods. A drop in oral contraceptive use from 52 percent to 37 percent largely has been offset by an increase in acceptors using injectibles, from six percent to 24 percent. For long-term methods, although the absolute numbers of VSC procedures have increased, VSC's percentage of total method mix fell from 25 percent in 1991 to 20 percent in 1994. This has been balanced by a rise in IUD use from 6 percent in 1991 to 10 percent in 1994.³

6.1.3 Constraints

Unmet demand. Between 1991 and 1994, demand for contraception increased from 41 percent to 52 percent of women, and the percent of demand met more than doubled (from 11 percent to 24 percent). In short, there was greater demand for services and a greater percentage of the demand met. FPSS support of IEC, training, and contraceptive logistics very likely contributed to improvements in both supply and demand. FPSS and the NFPP need to ensure that future training and IEC efforts are coordinated so that the demand generated can be met.

Trained providers. The 1992 Situation Analysis found that 63 percent of clients first heard of family planning at a clinic. This underscores the importance of and need for trained providers at the service delivery site for counseling as well as service provision. There is a large pool of untrained and inadequately trained providers that will require very heavy continuing NFPP inputs for training. (See Section 7, Training.)

Supervision. Another constraint is lack of supervision. According to INTRAH, most MCH supervisors have no training in family planning clinical skills and few have had supervision

³ These percentages are derived from detailed contraceptive use figures from the 1991/2 TDHS and 1994 TKAP which are presented in highly rounded form in Table 2.6, pages 80-81.

training. Although a supervisory checklist has been developed, it is currently being field tested, and supervisors are currently using a form developed for another purpose. Lack of transportation and travel funds contribute to an irregular supervision system. The amount and quality of supervision varies greatly in different regions, from once a month to three or four times a year. FPU is trying to respond to this problem by utilizing UMATI Area Teams to supervise all family planning services in the region, not just VSC. This is scheduled to start early in 1995.

Expendable supplies. The principal complaint voiced by service providers in the field is lack of expendable supplies. This is becoming increasingly important with growing demand for long-acting methods, such as IUDs and VSC, which mandate the use of gloves and other supplies. In some areas a cost-sharing approach is being utilized (clients pay for their expendable supplies) but results have not been evaluated.

Contraceptive supplies. Although there have been great improvements in the contraceptive logistics system, the growing demand for Depo-Provera may quickly exceed the supply. There were Depo-Provera stock-outs noticed on the MTR team's field trips.

Service standards. Although the service standards have twice been reviewed and liberalized, this information has been slow to reach front-line providers. Although a recent evaluation of INTRAH found that 69 percent of all trained providers had a copy of the service standards, the large pool of untrained providers has not received this information. It will take time to see resulting changes at the service delivery level. This information is currently in English and needs to be translated into Kiswahili.

- 8. Recommendation:** **USAID and UNFPA should reassess the requirements for Depo-Provera and possibly increase procurement to avoid future stock-outs.**
- 9. Recommendation:** **FPSS should monitor the progress of the UMATI Area Offices in conducting supervision and provide additional assistance if requested.**

6.2 Long-Term and Permanent Methods

6.2.1 Background

By 1991, UMATI, with AVSC assistance, had trained 21 counselors and 14 minilaparotomy teams (doctor/nurse teams). FPSS planned to expand VSC sites from two to 40 sites and perform 20,000 procedures annually by the PACD. UMATI was selected to facilitate VSC training, equip sites, and provide TA. Although FPSS was not specifically designed to address NORPLANT[®], studies to support its introduction began in 1991 at two sites with only one trained provider. No personnel had been trained in no-scalpel vasectomy (NSV) or postpartum IUD insertions.

6.2.2 Achievements

Voluntary Surgical Contraception. FPSS assisted in a systematic approach to expand VSC services including training of providers, refurbishing facilities, provision of expendable supplies, and supervision. This program exceeded its five-year targets halfway through the project. By mid-1994, 35 sites were fully operational and 10 additional sites were being upgraded, with 70 sites planned by 1995.

Resources. To date, FPSS resources provided for VSC have doubled from design estimates. This has allowed the project to expand at a rapid pace; nonetheless, services are still not satisfying demand.

Quality of services has been a primary concern of this program. UMATI ensures that providers are adequately trained in clinical skills and counseling, sites are refurbished to maintain good operating conditions, and supervision is carried out in a systematic manner.

NORPLANT®. Since 1991, the number of sites offering NORPLANT® insertions has increased from one to five and 1,000 implants have been inserted. UMATI intends to double the number of sites offering NORPLANT® to 10 and train 32 teams to insert 6,000 implants by the end of the project.

No-Scalpel Vasectomy. At the outset of FPSS, no one was trained in no-scalpel procedures. There are now five sites with trained providers that offer this method. By mid-1994, only 18 procedures had been performed. UMATI plans to add six additional sites with trained providers to offer this service.

6.2.3 Constraints

UMATI Management. One of the constraints to expansion of the long-term/permanent (LT/P) program has been its centralized approach, particularly in the area of training and management. With the current development of Area Offices distributed throughout the country, responsibility for training and management will be decentralized. These offices are still new and cover wide geographic areas. Because of planned expansion of activities, the Area Offices will need TA from the central office. The Mission has discussed with UMATI the possibility of providing long-term technical assistance to enhance program management at either or both the central and Area Offices. UMATI has not yet requested the assistance.

Unmet Demand. The originally modest objective of a five-year program to establish 35 VSC sites was exceeded in the first two years of FPSS support, and a new target of 70 VSC sites has been established after an assessment of the program. AVSC/UMATI supported 564 tubal ligations in 1990 using central funds. The number of procedures with FPSS support increased in 1991 to 2,094 and was 2,737 in 1992 and 3,871 in 1993. The increase in 1993 resulted in part from increased funds being made available for minilap training. Although there are 35

fully operational VSC sites relatively evenly distributed throughout the country, they are inadequate to meet demand. One important impediment to VSC services is the fact that they are only provided on certain days of the week based on the availability of a trained surgeon. Providers are beginning to realize that daily services must be provided in order to meet this demand. Lack of expendable supplies also contributes to delay in the provision of long-term methods.

Training. The lack of trained providers has greatly impeded the expansion of VSC services. The high attrition rate of surgeons originally trained in VSC due to promotions and transfers severely limited service provision. The VSC strategy has been modified to train clinical officers who are transferred less frequently.

- 10. Recommendation:** **FPSS should continue to support the expansion of LT/P through the project completion date. An additional \$2.0 million will be required to increase VSC and nonsurgical vasectomy sites, train additional providers, and provide supplies/equipment to serve VSC, NSV, NORPLANT[®], and IUD clients.**
- 11. Recommendation:** **FPSS should work with UMATI to identify the type of long-term TA required to strengthen program management of the program at both the central and area office level. (Possibly a Michigan Fellow).**

6.3 Community-based Distribution

6.3.1 Background

Community-based and workplace distribution, as alternatives to facility-based provision of services and delivery of contraceptives, have not yet reached their full potential in Tanzania. The FPSS Project Paper discusses CBD only as one possible element of the contraceptive supply and logistics strategy as follows: "In the later years of the project, [contraceptive] kits may be made available to village health workers and traditional birth attendants for community-based distribution...." Thus, there are no targets or indicators in the Project Paper against which progress in the implementation of CBD can be assessed. Although a community-based distribution program was implemented by the Seventh Day Adventist Church (SDA) Medical Services as early as 1985 and by UMATI in 1987 with funding from Pathfinder, only in 1992 did the Ministry of Health identify CBD as a potentially effective method of service delivery for family planning. Following on this, a national strategy for CBD was developed in 1993. This activity was conducted with technical assistance by Pathfinder.

Community-based distribution has a great deal of potential for addressing demand-related issues in family planning. A key issue is the quality, efficiency, and effectiveness of service delivery, including confidentiality and privacy. Community-based strategies are very likely to

be effective in ensuring confidentiality. A further consideration is the delivery of FP services and commodities to male as well as female clients. Community-based distribution employing male as well as female agents is well-placed to serve the needs of men and women acceptors, as well as provide IEC designed to overcome couples' reluctance to discuss issues related to family planning.

6.3.2 Progress and Achievements

At present, community-based distribution services supported by FPSS are provided under the auspices of a number of different organizations, including the FPU, UMATI, the Seventh Day Adventist Church, and the Organization of Tanzanian Trade Unions (OTTU). The UMATI program has been implemented in Kinondoni, Temeke, Ilala, and Kisarawe districts, with 151 active volunteer CBD agents and nine field supervisors. The SDA program is active in Arusha, Dar es Salaam, and Mwanza, fielding 99 full-time, salaried community service providers. The newly implemented OTTU/Tanzania Occupational Health Services (TOHS) worksite-based program utilizes the services of both clinic nurses and volunteer peer educators, beginning with 11 Dar es Salaam worksites in 1994. The peer educators are already active and have been trained in HIV/AIDS under another USAID project. The SDA program and some of the OTTU activities are clinic linked, while UMATI CBD agents are freestanding but receive backup from UMATI supervisors and referral facilities. The populations served are a mix of urban, rural, and workplace populations. These FPSS-supported activities are quite variable in their effectiveness as measured by quantities of contraceptives distributed, numbers of clients contacted, persons trained, gender mix of CBD agents, and meetings held. Although a national CBD strategy has been developed, these existing programs show marked differences from one another in how closely they model themselves on the basic principles of the national strategy implementation plan.

Despite the structural differences that exist between the various FPSS-funded programs, the 1994 Pathfinder assessment of the SDA and UMATI programs found that they all share several strong points. Client response is very positive; clients feel that the services provided are convenient and meet their needs. Both UMATI and SDA have institutional strengths and commitment to the CBD strategy. Community support is also apparent, particularly in the case of the UMATI program.

6.3.3 Gaps and/or Constraints

Geographic Coverage. Although a mix of different CBD focuses (rural, urban, worksite) is found, there is a concentration of service provision in urban areas (particularly Dar es Salaam) that do not have a low density of service delivery points (SDPs). Rural services are being implemented in just a few areas (Iringa, Dodoma, Tabora, and Coast by UMATI and FPU). These areas are not necessarily less well-served by fixed facilities than other areas that do not have CBD programs, nor are they localities with conspicuously low contraceptive prevalence rates. Since a powerful rationale for CBD is its potential to reach the isolated or reluctant

consumer, consideration should be given to expanding coverage in areas with low CPR and widely dispersed service sites.

Supervision and Training. Supervision and training of CBD agents is somewhat of a problem area. On the side of supervision, resources are limited, transportation is constrained, and there are multiple competing demands on the time of the supervisors (who are often Maternal and Child Health Aides [MCHAs] with minimal management skills or volunteers with limited free time). The content and duration of training also are highly variable and often not in conformity with the standards recommended in the national strategy. The UMATI agents receive three weeks of training and have not had any refresher training for three years. CBD agents under the FPU programs also receive three weeks of training from MOH staff who train TBAs as well. The SDA CBD agents, who are full-time salaried workers, receive only five days of training which may be inadequate to permit them to carry out their duties effectively.

Commodity Supply. The CBD assessment of UMATI and SDA conducted by Pathfinder faults both organizations in the area of commodity control and supply. Contraceptives are provided to the implementing organizations through the MOH or UMATI, but distribution to the CBD agents is in the hands of the organization, which is often hampered by lack of transport, poor information on resupply needs, and physically dispersed individual CBD agents. Understocking, overstocking, stock-outs, expired and/or damaged contraceptives were observed by the Pathfinder team at many sites. CBD agents are often not resupplied on any regular basis. Storage facilities are also inadequate in both programs. IEC materials are not routinely provided to CBD agents in any program.

Reporting and Monitoring. Both projects suffer from inappropriate data collection and reporting methods. The reporting formats are criticized as being cumbersome, prone to inaccuracy, and the use of the data collected for any kind of self-assessment or even for easing the resupply of contraceptives is limited. Such shortcomings are frankly acknowledged by UMATI staff.

Incentives. The issue of the payment of incentives to CBD agents, whether in cash or in kind, is a complex one. There is great variation in the professional status and types of incentives offered to the CBD agents in the SDA, UMATI, and OTTU programs. Some (SDA) are regular salaried employees; the FPU CBD agents have received bicycles and a monthly maintenance allowance of TSh. 1,000; UMATI agents in Mgeta, Morogoro, explicitly requested flashlights, shoes, satchels, and scissors during a meeting with members of the MTR team. Although the national strategy document strongly advocates the provision of incentives in the form of stipends, equipment, and/or allowances, noting also that such packages should be consistent, there is enormous variation from activity to activity.

12. Recommendation: **FPSS should support the development of further facility-linked rural, urban, and worksite-based CBD programs with the objective of extending CBD services to underserved rural areas with low CPR.**

- 13. Recommendation:** FPSS, NGOs, and FPU should collaborate to develop a standardized and simplified reporting format for contraceptives distributed by CBD agents suitable also as the basis for resupply of commodities to the CBD agents.
- 14. Recommendation:** FPSS, FPU, and NGOs need to develop standardized CBD agent and supervisor training materials and training/retraining courses.
- 15. Recommendation:** FPSS should encourage HED and JHU/PCS, SDA, and UMATI to develop appropriate IEC materials for distribution to CBD agents through all CBD programs. (UMATI presently is testing CBD IEC materials designed specifically for use in the Dar es Salaam area.)

7. TRAINING

7.1 Background

Scarcity of trained service providers was identified as a major obstacle to the delivery of quality FP services during FPSS design. The 1992 Tanzania Situation Analysis revealed that 88 percent of providers stated that their training in FP was inadequate, and only 29 percent of them had been trained during the previous five years. There was only a handful of sites that were adequate to serve as training facilities.

In 1991, training materials were scarce and inadequate and training was conducted without standard curricula or coordination. Preservice curricula had some FP information, but they were outdated and inadequate in terms of time allocated to the subject. FPU only had one person to coordinate training throughout the country. Although the National Training Strategy was the cornerstone for training, its target was very ambitious (e.g., 6,000 providers were to be trained in three years in basic family planning skills). FPSS planned to provide \$2.7 million for training activities.

7.2 Progress and Achievements

7.2.1 Strengthening The FPU

With FPSS and UNFPA assistance, the FPU training section has grown from one to five professionals between 1991 and 1994. This section, comprised of a training coordinator, an assistant coordinator, and three trainers, forms the Central Training Team (CTT).

One indicator of increased capacity is management of funds. In 1993, FPSS provided the FPU training section approximately TSh 47 million to carry out activities and 315 providers were oriented to family planning. In 1994, the amount provided was increased to TSh 239 million. So far, 120 providers have been trained in comprehensive family planning skills solely by FPU in addition to 229 providers given similar training with INTRAH assistance. This training is much more intensive and costly than the orientation.

INTRAH has participated in strengthening the FPU capacity by providing a resident trainer to 1) assist in solving day-to-day problems, 2) assist in the planning and organization of training courses, 3) participate in all training materials development, and 4) assist the development of the National Training and CBD Strategies.

The SEATS Project also provided local and off-shore training opportunities to enhance the level of skills possessed by FPU staff (see Table 7.1, page 82).

7.2.2 Training Resources

FPSS has been able to reprogram funds within the project to provide more support for training activities. In 1991, \$2.7 million (13.6 percent of total project budget) was programmed for training. By 1994, \$5 million, or 25 percent, had been obligated for training. This includes funds provided directly to FPU, \$1.5 million transferred to INTRAH for paramedical training, and \$2.3 million transferred to AVSC to work with UMATI for VSC training and service provision. Without these funds, FPSS could not have made the achievements that are reflected throughout this document. Additional resources will be required to continue support for this important NFPP component.

7.2.3 Establishing a Training System

INTRAH was identified to assist the MOH in planning and conducting this training effort. The training has been very effective; there is a marked rise in the knowledge and skills levels of those who have received training, particularly the clinical skills component. Although this has been a successful start, the task for establishing a training system of the magnitude necessary to respond to the needs in Tanzania is a daunting one. The current National Training Strategy indicates that approximately 12,000 persons need to be trained by 1999 at a cost of \$25 million. FPSS has been a major contributor to family planning. Additional resources, however, need to be identified.

INTRAH has been successful, in part, because of its ability to adapt its strategy and be responsive to the needs in the field. For example, initially the focus of the training program was on the development of decentralized training teams. While this is still urgently needed, INTRAH and FPU recognized early that there were not adequate numbers of providers trained in clinical family planning skills to form them into training teams. The emphasis now has shifted to first train service providers and allow them to develop clinical skills prior to being prepared as trainers.

Although takeoff of in-service paramedical training was slow, FPU was able to establish its CTT and train five Regional Training Teams (RTTs). In order to provide effective training, service delivery sites had to be fully equipped so that service providers could be appropriately trained. FPSS responded to this by equipping 30 practicum sites for training purposes. INTRAH utilized core funds (\$300,000) to procure the equipment sets for the 30 sites. An additional 30 sets are planned to be procured in late 1994.

7.2.4 Training Standards and Reference Materials

FPSS has assisted FPU in the development of a wide array of training instruments. This capacity has been institutionalized within the FPU and, to a lesser degree, within the RTTs.

Training instruments include the following:

- Curricula for all six types of training courses
- FP Procedure Manual
- FP Service Standards and Guidelines
- Trainers' Guide
- FP Supervision Checklist (still being tested)

These training instruments have contributed to the standardization of training throughout the country and serve as reference material for providers. The development of these documents has been a valuable experience in building confidence of the trainers. In addition, the eight Trainers Reference Libraries and five Clinicians Reference Libraries established have served as worthwhile resources for the trainers.

7.2.5 VSC Services

Progress in this area has been outstanding; all training targets have been exceeded by UMATI in approximately half the amount of time initially planned (see Table 7.1, page 82).

7.2.6 NORPLANT[®]

At the outset of FPSS, NORPLANT[®] was still undergoing studies to promote its introduction, and there was only one trained provider. Five sites now offer services by trained providers and over 1,000 implants have been inserted.

7.3 Constraints

7.3.1 Regional Training Teams

The major constraint to the implementation of in-service training is the lack of a critical mass of trainers well versed in clinical FP skills. There are only five RTTs for 20 regions. Sadly, of the 74 regional trainers trained, only 22 are actively training. This is primarily attributable to the earlier inadequate selection process of trainees and high attrition rates for multiple reasons. At project onset, it was assumed that a critical mass of trainers would not be hard to find. In fact, most supervisory personnel selected to become trainers had no clinical skills in FP. This significantly slowed down training. Currently, the focus is on training service providers and allowing them to gain clinical experience prior to their selection as trainers.

7.3.2 Supervision

Although 19 persons have been trained as preceptors, supervision is still a major constraint to the expansion of quality FP services. Most regional MCH coordinators have had minimal or no training in FP, particularly in clinical methods. Without this clinical training, these supervisors

do not have a rational or systematic way of assessing improvement in performance of their sites. A supervisory checklist currently being field tested is too long for practical use. Supervision training should be accelerated.

7.3.3 Dissemination of Training Documents

Although the training documents are very progressive, little of this information has actually reached the frontline providers. The procedure manual also does not fully coincide with the FP Policy Guidelines and Service Standards, so there are still many misconceptions and provider biases that need to be addressed.

7.3.4 Preservice Training

The intent of the planned preservice training was to prepare medical and nursing students to be competent FP providers upon graduation. Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) made two attempts to institutionalize FP into the medical and nursing schools without success. First, UMATI trained 50 tutors from nursing and MCH Aide schools. This activity was instrumental in building the tutors' confidence in FP, but they proved ineffective in transferring their knowledge and skills due to time constraints within the curriculum. Second, the Muhimbili Medical School was assisted by JHPIEGO to incorporate FP into the medical curriculum, but this was never accomplished. Due to inadequate time during their studies, students were unable to acquire practical skills in FP that would allow them to be competent providers. Although draft curricula were developed in both cases, they were not formally adopted by the MOH or the schools.

The fact that medical and nursing graduates are not competent to provide quality family planning clinical services upon graduation is disappointing. Many graduates will be supervisors who do not possess adequate FP skills but are responsible for the treatment of complications and supervision of these services, especially by doctors. For long-term sustainability, this warrants re-examination of preservice training constraints and challenges.

7.3.5 Lack of Equipment and Supplies

Although the training environment for providers is adequate, many times upon return to their sites they are unable to provide quality services due to lack of equipment, expendable supplies, or contraceptives. These issues need to be addressed to ensure expansion of quality FP services.

16. Recommendation: **FPSS should support the acceleration of training for clinical skills for service providers and strengthen the capacity of the Regional Training Teams.**

Although there are constraints in terms of absorptive capacity (e.g., training sites and client load), the Mission should explore possibilities to accelerate the training. One possibility is to bring in more external TA to actually conduct the training with the RTTs (six to eight months). This would also increase the RTTs' capabilities.

- 17. Recommendation:** **There will continue to be a substantial amount of short-term and long-term TA for training required until the end of the project. FPSS, however, should begin with FPU to develop a strategy that identifies how TA will be phased out and how FPU will assume these responsibilities.**
- 18. Recommendation:** **FPSS should support a workshop of relevant parties to develop an action plan that will expand and update the FP content in the current preservice curricula (Medical, Nursing, and MCH Aide).**
- 19. Recommendation:** **FPSS should accelerate supervisory training so that the majority of supervisors are trained by December 1995. USAID may wish to engage the services of a management organization for this purpose.**

8. INFORMATION, EDUCATION, AND COMMUNICATION

8.1 Background

The IEC component of FPSS involves a number of activities, the most important of which include materials production and distribution to serve providers and clients, provision of materials to support private sector family planning efforts, and baseline and follow-up KAP surveys and focus group discussions in selected districts. Project activities commenced in 1991 with the Tanzania Family Planning Communication Project, initiated by the Health Education Division of the Ministry of Health with technical assistance from Johns Hopkins University/Population Communication Services (JHU/PCS). The overall purpose of the IEC component is to increase utilization of modern family planning methods. The project seeks to increase the proportion of men and women of reproductive age having positive attitudes towards modern family planning methods, increase the number of people accepting and continuing to use modern family planning, and improve the quality of family planning information provided to clients.

8.2 Progress and Achievements

A number of major initiatives have been implemented under the IEC component of FPSS.

8.2.1 Baseline and Follow-Up KAP Studies and Focus Group Discussions in Selected Districts

In 1991, a family planning KAP study involving 1,591 respondents was conducted in six districts of Tanzania representing both rural and urban areas. This study showed that the pill was the best-known family planning method, spontaneously mentioned by 58 percent of respondents, followed by the condom (44 percent), IUD (19.5 percent), injection (17.5 percent), and tubal ligation (7.5 percent). Comparison of baseline with follow-up data collected in 1994 from 1,574 respondents indicates that spontaneous knowledge of modern methods measurably increased in the three-year interval between surveys, while acceptance of rumors and misconceptions about family planning declined, ever and current use of modern family planning increased slightly, and client attendance at FP clinics in the surveyed areas rose.

8.2.2 National Family Planning Logo

In May 1993 the national FP logo, the Green Star, or Nyota ya Kijani, was launched at a public ceremony in Dar es Salaam which was attended by the Minister of Health on behalf of President Ali Hassan Mwinyi. Regional launches have been carried off in Mwanza, Mbeya, and Arusha only. The Green Star logo has been popularized throughout the country by the distribution of 5,000 T-shirts, 10,000 badges for trained service providers, 35,000 three-

dimensional badges, 1,500 Green Star stickers, 5,000 large weather-proof decals, 500 satchels with the logo, 1,000 brochures explaining the origin and meaning of the Green Star as a family planning symbol, 1,500 caps, and 1,500 flags bearing the Green Star logo.

The Nyota ya Kijani logo is the most widespread and visible symbol of the National Family Planning Program. It can be seen at most SDPs in the country as well as on vehicles. The badge is worn by many FP service providers. However, the 1994 TKAPS shows that only a minority of respondents (17 percent nationwide) recognize the logo as a symbol of family planning. Further regional launches and increased publicity should increase recognition.

8.2.3 Print Materials

To date, approximately 2.5 million leaflets, wall charts, and posters have been printed, in the following categories:

Posters/Charts:

Economic benefits for men	41,250
Positive image of FP service provider	41,250
Family welfare benefits of modern FP	41,250
Wall chart of modern methods	5,250

Leaflets:

All methods	1,000,000
Pill/injectable/IUD	480,000
Condom/diaphragm/foam tablet	480,000
Permanent methods	380,000

These materials have been distributed using two strategies. Some of the materials were targeted to the project areas located in seven districts of mainland Tanzania where the baseline and follow-up family planning KAP studies and focus group discussions were carried out in 1991 and 1994. As noted above, these surveys show some positive indications of enhanced knowledge of family planning issues. These same leaflets and posters have also been distributed to 18 of the 20 regions in mainland Tanzania—1.8 million leaflets and over 100,000 wall charts and posters. This distribution has been slower than desired, however, and it is unclear what proportion of the materials has made its way from region to district and from district to SDP. Production of additional materials is needed to ensure nationwide coverage with more effort to ensure distribution from districts to SDPs.

8.2.4 Radio Program

A radio soap opera, Zinduka or Wake up!, has been developed and is being broadcast twice a week. There are presently 52 episodes, complemented by 10 radio spot announcements on

FP issues. The program carries positive messages about family planning and sometimes stimulates listeners into discussions regarding issues which ordinarily are not public fare. Audience surveys in the form of focus group discussions have indicated high exposure (54 percent of clients interviewed at three family planning clinics in Kisarawe in 1994 had listened to the program) and positive assessments of the program. Radio is a highly effective form of communication and source of information in Tanzania, and the recent inauguration of television on the mainland would allow expansion of nonprint media IEC.

8.2.5 Audio Cassettes

A cassette which seeks to promote communication between social groups and couples on family planning issues has been developed. The cassette has been distributed to 600 couples as a pilot activity with the hope that the results will warrant refinement and further distribution.

8.2.6 Institution Building

An important objective of the IEC project is to build capacity in the HED. Substantial short-term technical assistance has been provided through JHU/PCS; in addition, a number of HED staff members, as well as individuals from other organizations, have received explicit IEC management training through JHU/PCS. Project management skills and other technical training have also been provided.

8.3 Gaps and/or Constraints

Although achievements of the FPSS IEC component are substantial, there are both gaps and constraints to program success. The quantity of leaflets produced so far does not seem sufficient to inform the large number of clients with identified unmet demand for family planning services. This will be rectified in the next phase of the IEC program, and materials will be supplied to the two regions (Dodoma and Coast) which were not included in the initial distribution. In addition, new topics and themes for IEC materials should be explored, with particular attention to potential male clients and adolescents and to encouraging openness and communication between partners on family planning issues.

Apart from insufficient supplies, transportation of the materials from central to regional level and from the regions to districts and SDPs is also a bottleneck. The problem becomes more severe from the district level downward, as distribution is the responsibility of district MCH/FP coordinators who do not have any means of transport under their control.

Program management in the HED also has raised some questions. Although considerable short-term TA and management, as well as other forms of training, have been provided, coordination among JHU, USAID, and HED remains a problem. Long-term or resident TA, which has now been agreed to by USAID, the MOH, and PCS, will assist in meeting unfulfilled expectations for FP IEC.

The Tanzanian cultural environment, as is the case everywhere, imposes its unique constraints on the ability of potential clients to gain access to IEC materials and to assimilate them. Although women are the main consumers of MCH/FP services, their decisions about accepting FP are often influenced by their partners or their perceptions of the views of their partners. Materials which would influence the views of men and/or encourage them to discuss the issue of contraception with their partners are very much needed. Since more women than men are illiterate, in some cases targeted nonprint approaches will be needed to reach some female consumers. The content of radio spots and the Zinduka soap opera should take possible variations in audience composition into account.

Coordination of IEC activities is also important. The FPU, HED, UMATI, the Population and Family Life Education Program (POFLEP) (a UNFPA-funded IEC program in the Ministry of Community Development, Women Affairs, and Children), and other organizations such as GTZ and UNFPA are all involved in materials production and distribution to some extent. Mechanisms are needed to ensure collaboration and cooperation among these various government, NGO, and private agencies. Such collaboration would reduce duplication or the possibility of the dissemination of competing or conflicting messages by different agencies and providers. Such coordination and collaboration would be facilitated by the creation of an IEC/Research Coordinating Committee, as proposed in the Project Paper. Although the FPU has in theory convened an IEC Technical Committee which is to include the participation of all agencies concerned with family planning, in practice the committee is not active.

An important element in an effective IEC program is adequate training and support for FP service providers to ensure that they advise and counsel clients appropriately. Fully informed providers are needed who can discuss contraceptive options with clients in confidential settings and ensure that the correct information is both presented to and understood by the client.

8.4 Recommendations

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| 20. Recommendation: | Since the creation of a resident advisor position within the HED has been accepted in principle by all of the interested parties (USAID, JHU/PCS, and the MOH), a Scope of Work should be developed and recruitment for the position should get under way as soon as possible. |
| 21. Recommendation: | The IEC resident advisor should work with the HED and FPU to accelerate the production and facilitate the distribution of IEC materials. |
| 22. Recommendation: | The resident advisor and USAID should work to ensure that an IEC/Research Coordinating Committee or IEC Technical Committee is in fact established and holds regular meetings. |
| 23. Recommendation: | FPSS should encourage agencies involved in IEC activities, particularly PCS and HED, to work together to expand the use |

of radio and other nonprint media, including television, videos, film shows, and folk performances.

- 24. Recommendation:** The PCS resident advisor should work with the FPU and other organizations/groups to upgrade and strengthen the FP service provider counseling training curriculum.

9. PRIVATE SECTOR

9.1 Background

The Project Paper includes a private sector component, funded at \$1 million or around 5 percent of LOP. To date, approximately \$2 million has either been expended or committed for family planning activities in the private sector. The purpose of this component is to increase access to family planning and broaden the institutional base for family planning service delivery by increasing the capacity of parastatals and private organizations to deliver such services to their members and employees. With the exception of the role that UMATI was expected to play, FPSS took a somewhat cautious approach toward increasing the involvement of the private sector in family planning service delivery.

Initial emphasis was placed on the expansion of clinic services, in particular VSC, within the public sector to consultant and regional hospitals, with later expansion into those private sector (workplace) and NGO clinics that expressed an interest in providing these services. Although by PACD it was expected that at least 20 private or parastatal health facilities would be able to provide long-acting contraceptive methods, including VSC, this was not expected to be achieved until the latter part of the project. Small-scale pilot activities and efforts to get the government both to accept and encourage greater private sector involvement in family planning service delivery, however, were to take place early in the project. Contingent upon their success, it was felt that broader family planning service delivery efforts might be extended to additional private/NGO health facilities. It was also felt that during the latter part of the project, the condom social marketing program (begun in 1990 for AIDS prevention) might be expanded to include other contraceptives.

9.2 Progress and Achievements

9.2.1 Expansion of Long-Term and Permanent Methods

With regard to expected achievements in the private sector, FPSS is making satisfactory progress. UMATI has been designated by the MOH to be the national coordinator and trainer in LT/P family planning methods, as well as the organization responsible for development of family planning activities with the NGO and private sectors. Working with technical assistance from AVSC, UMATI has expanded LT/P methods to 35 sites (nine private sector, two parastatal, 24 public sector) and, at the behest of USAID/Tanzania, is in the process of expanding services to an additional 35 sites (15 private sector, 20 public sector). In addition, working with UMATI, Marie Stopes International (with AVSC support) will initiate a two-year pilot project in October 1994 to improve and expand access and acceptance of quality clinical family planning services in 12 private sector sites (hospitals and clinics). This activity is expected to produce the experience and information needed for a possible expansion of this effort to private sector clinical sites throughout the country.

9.2.2 Expansion of Family Planning Services into the Workplace

An operations research (OR) project with TOHS was completed by The Population Council in 1993 that underscored the feasibility and effectiveness of implementing family planning activities at the work site in Tanzania. It also showed that integration of HIV/AIDS and family planning information and services is an effective way of providing both services. Based on these findings, a three-year workplace subproject was initiated in January 1994 under FPSS through Pathfinder International. This activity, which is being implemented by the OTTU in collaboration with TOHS, will provide clinical family planning services, including VSC, integrated with AIDS control activities in the workplace of 26 companies with a workforce of at least 1,000.

9.2.3 Expansion of NGO Community-based Distribution Activities

In 1988, Pathfinder initiated centrally-funded pilot CBD programs with UMATI and SDA. The UMATI "stand-alone" CBD program focused on four rural districts surrounding Dar es Salaam. This activity was redesigned and extended for three years in 1993 to increase UMATI's management information system (MIS) and supervisory capabilities, add a youth component, continue training of CBD agents and community leaders, and correct for noted weaknesses. A May 1994 evaluation of the program by Pathfinder found that it has been well received by clients but has suffered from attrition of CBD agents (30 percent to 40 percent annually). At the same time, when CBD agents have been selected by communities, there has been no mechanism in place to provide orientation or training to them and many have not received essential equipment to assist them in their work. In most cases the CBD agents do not have a good grasp of contraceptive technology and clinical methods, severely restricting their referral capability.

The "clinic-linked" CBD program with SDA, also funded with central funds, was originally aimed to provide family planning through 47 of SDA's 50 clinics. When this proved overly ambitious, the program was redesigned in 1992 to focus on the development of five "model clinics" to serve as full-service centers of excellence for introducing CBD activities in surrounding catchment areas and another 10 "priority clinics" in the same areas which had potential, with technical assistance and intensive monitoring, to become model sites. The remaining clinics in the SDA network were to continue to receive contraceptive supplies only. The 1994 Pathfinder evaluation found that, while both clinic staff and CBD agents were making a good effort to meet project objectives, major weaknesses remained in management and supervision, the training of both clinic staff and CBD agents, and in maintaining an adequate supply of contraceptives (see Section 6.3.3 for more detailed discussion). The MTR team noted these same weaknesses during its field visits, particularly the lack of well-trained CBD workers, supervisors, and clinical staff. The new program, which will run until 1996, is intended to strengthen the model clinic concept by improving program management and overcoming these identified weaknesses.

In the UMATI program it is expected that by 1996, 35,000 new users will be added to the family planning program, 30,000 will be referred for LT/P methods, and over 550,000 will have been reached with family planning information. The SDA program expects to reach over 800,000 people with family planning information and generate 25,000 new family planning users.

Although the cost of CBD programs may be expensive up front, once solid demand is created and women (and men) understand that family planning is safe and effective, they will go far to obtain methods on their own. CBD programs can eventually be phased out or CBD agents can set up a depot for supplies and clients can come to them.

9.3 Private Sector Expansion Potential

9.3.1 Favorable Climate for Private Sector Expansion

Since The FPSS Project started, the climate for increased private sector involvement in family planning service delivery appears to have changed considerably, as the government has liberalized the economy, and now offers a "window of opportunity" for the project to achieve far more in this sector than was originally envisioned. A greater role for the private sector has been articulated in the new National Family Planning Strategic Plan (1994–1999), which has just been approved, and the government is considering liberalizing the licensing of a greater range of health care practitioners to allow them to provide services privately.

UMATI has identified expansion of family planning services in the private sector as one of the three pillars of its own service provision strategy. In line with this it has initiated, with IPPF funding, a project entitled "Family Planning for the Private Sector." This project, which is already in its second year, has trained 39 service providers from 39 private institutions in the provision of high-quality family planning services. In conjunction with this program, UMATI is receiving assistance from INTRAH to strengthen its training capabilities. UMATI also has put an administrative structure in place to continue expansion of this program, i.e., it has deployed a private sector coordinator to each UMATI area office. These coordinators are required to identify private sector organizations with clinics that can deliver family planning services and are willing to provide administrative support for the provision of such services in the workplace. Although this program has been running for only a year, feedback indicates that it is well received both by the companies and their employees. UMATI staff provides the training for the service providers and ensures that those institutions participating in the project are adequately supplied with contraceptives. A field visit during the MTR to the second training course for private sector providers, however, indicated there may be problems in ensuring the private sector clinics where the trainees serve are fully equipped to provide the range of services for which they are being trained. To date this activity has included for-profit, voluntary, and parastatal organizations.

9.3.2 For-profit Sector

While FPSS has initiated a pilot activity with the for-profit sector (OTTU/TOHS), this is only expected to reach a small fraction of the 700,000 people employed in the formal sector workforce in Tanzania (14 percent of whom are women). There are approximately 2,500 clinics run by private companies that provide health services to this population, yet most do not offer MCH/FP services due to lack of trained staff and inadequate supplies and equipment. As a consequence, the for-profit private sector provides only 7 percent of the family planning services provided in Tanzania today (NGOs provide another 14 percent). The FPSS-supported work-based OTTU/TOHS project mentioned above will begin developing this potential, as will UMATI's private sector project; yet, far more could be done. OTTU itself has almost 3,000 field branches in 22 regions and 90 districts with 23,000 elected field branch officials, of which 6,000 are women. TOHS has 12 of its own clinics and provides services to approximately 100 companies and government agencies (family planning is provided in only four of these to date). In addition, it supervises other clinics serving another 200 companies. The potential of these clinic networks to serve as channels for provision of the full range of family planning services to employees and their families must be considered substantial.

9.3.3 Christian Medical Board of Tanzania

Another network which appears to offer considerable potential for delivery of family planning services is the Christian Medical Board of Tanzania (CMBT). This association represents 79 hospitals, 15 health centers, and 575 dispensaries located in almost every district of the country. Nineteen of these hospitals are actually designated as district hospitals even though church operated. CMBT estimates that its member facilities provide 45 percent to 50 percent of all health services in Tanzania today and have just under half of all hospital beds in the country. While approximately half of the facilities are Catholic-run, the CMBT has indicated a strong interest in undertaking a program to strengthen the family planning services of its members if such a program could be tailored to the individual requirements of its member facilities. Initial discussions with UMATI indicate that it could establish such a program for supporting family planning IEC and service delivery training for CMBT.

9.3.4 Professional Associations

Two associations of health practitioners have also been established in Tanzania, the Tanzania Midwifery Association (TAMA) and the Medical Women's Association of Tanzania (MEWATA). TAMA currently consists of 200 members (there are 20,000 practicing midwives in Tanzania), while the Medical Women's Association consists of approximately half of the 120 women physicians working in Tanzania. About 10 percent of the former and almost all of the latter members of these associations work in the private sector as well as hold public sector jobs. Although it is probably too early to consider them for more than limited project assistance, these associations may possibly become a viable network for delivery of services in the future, for advocacy, and for monitoring and policing the quality of services provided by private practitioners. This latter role could prove especially important if the GOT liberalizes the

licensing of a greater range of private practitioners, as such a step is expected to result in a proliferation in the number of private sector clinics in the country.

9.3.5 Commercial Sales

Commercial sales of contraceptives in Tanzania are common, although validated data are difficult to obtain (the 1991/92 TDHS shows that 5 percent of contraceptives are currently obtained from pharmacies). Most pharmacies sell one or more brands of oral pills, condoms, and a few occasionally sell IUDs, such as the CUT380A. Visits to pharmacies by the MTR team found this to be the case. Most of the commodities in these retail outlets appear to have come from public sector sources and therefore can be assumed to be diverted product. Nevertheless, such a situation, and the fact that in the TDHS 29 percent of those using contraceptives obtained them from private sources, clearly indicate that a potential commercial market exists for these contraceptives.

The USAID-supported condom social marketing program which is being implemented by Population Services International (PSI) under the The AIDS Control and Prevention Project (AIDSCAP) also appears to offer considerable potential and a cost-effective way to introduce other contraceptive methods to the commercial market, in particular oral contraceptives and possibly Depo-Provera. Much of the groundwork has been done to build a commercial distribution network which could easily accommodate pills as well as condoms. From discussions with PSI, it appears that the pill could be added to the program for a two-year trial period for approximately \$500,000. PSI also feels that it could introduce an oral contraceptive into the Tanzanian market which could sell for approximately one-fifth the price being charged in the commercial sector per cycle (the MTR team found cycles of oral contraceptives selling from TSh 60 to TSh 150 per cycle). Such a trial period would show whether or not a viable market for this contraceptive exists currently or could be created through this approach. It might also be prudent for the public sector to consider some form of social marketing of contraceptives through the nationwide network of retail and wholesale pharmaceutical shops operated by the National Pharmaceutical Company (NAPCO), especially since it appears that public sector commodities are already being marketed through this retail network. Such an approach, which might include tying NAPCO into a social marketing program administered by PSI, might serve to hinder the diversion of public sector contraceptives to these shops.

9.3.6 Community-based Distribution

Should the CBD programs of UMATI and SDA prove successful and cost effective, there would be substantial potential for these programs to be expanded by both organizations, especially in rural areas that would not be well served through the above private sector channels. The "stand-alone" and "clinic-based" models being tested in these projects might also be expanded to other "network organizations" or even to the public sector. One such network organization is the Union of Tanzanian Women (UWT), an organization which reaches throughout the country and has 1.5 million members. The Centre for Development and Population Activities (CEDPA) is currently developing a small pilot project with UWT to determine how such an organization

might be used to deliver CBD services in underserved areas of Dar es Salaam. They will also look at the potential of adding CBD services to clinic-based programs such as Marie Stopes International clinics. Again, should this prove successful and cost effective, the potential exists to expand such a program to all parts of the country, including rural areas.

9.3.7 Scenarios For Expansion

There are two possible scenarios which FPSS could take with respect to private sector expansion. First, assuming the PACD remains fixed and the project has three more years to run, the project could continue laying the foundations for expansion and institutionalization of family planning services in the private and NGO sectors through support of pilot activities and support for coordination of efforts in the private sector. All of the pilot activities mentioned above will run for the next two to three years. The lessons learned from these activities, as well as from non-USAID-funded activities, such as UMATI's private sector initiative, should provide the basis for program expansion, at least in those areas of the private sector where the pilots took place. Such information would also be invaluable in the design of a private sector component for a follow-on project.

A second scenario would be to take a more comprehensive approach to family planning expansion in the private sector with the aim of institutionalizing a capability within Tanzania to continue to expand the program into the future. It is felt that this would take from five to six years to achieve and, therefore, probably entail an extension of the PACD as well as additional funding. Such an extension would allow sufficient time to develop the capability, preferably in UMATI, to manage such a program.

9.4 Gaps and Constraints

The principal gaps and constraints to development of greater private sector involvement in family planning service delivery center on inadequate information regarding how to achieve this objective. As shown above, there are already a number of pilot schemes underway in the country, many of which are being supported by FPSS. In most cases, however, the various activities have been developed without consideration of other happenings in the private sector.

The time appears right for development of a more comprehensive and coordinated approach to private sector delivery of family planning services.

9.5 Recommendations

- 25. Recommendation:** **FPSS should support an assessment of the private sector leading to the development of a short-term to medium-term strategy/action plan for expanding family planning services through private sector channels.**

This strategy/work plan, which should be developed with all current as well as interested parties (UMATI, OTTU, CMBT, Marie Stopes, etc.) would identify common objectives and the role each organization would play. Once this was completed, activities could be planned and budgets developed. If this is not done, there is likely to be considerable overlap in the objectives the various projects are trying to achieve, e.g., the OTTU and UMATI private sector activities. It is estimated that the cost of the assessment would be approximately \$100,000 and a strategy development workshop approximately \$20,000.

26. Recommendation: **Once the strategy/action plan for private sector expansion is developed, FPSS should initiate pilot activities with CMBT (possibly through UMATI), PSI for marketing the oral contraceptive and possibly Depo-Provera, and medical associations. Pilots might also be developed with other targets of opportunity, such as those with UWT.**

It is felt that, if initiated within the next few months, successful pilots could be implemented by the current PACD. The funding required for the three pilots identified above is estimated to be \$1.1 million.

10. CONTRACEPTIVE LOGISTICS

10.1 Background

The FPSS design recognized the inadequacy of contraceptive supply as a major constraint facing the provision of family planning services. "Irregular and insufficient delivery of contraceptives to service points" is listed in the Project Paper as the first explanation for the poor programmatic performance. Less than six percent of health facilities reported on contraceptive stock levels. Ordering at the national level was haphazard, and quantities shipped were inadequate. Maldistribution led to stock-outs in some areas, while overstocking occurred elsewhere. UMATI was responsible for the forecasting, warehousing, and transport of contraceptives. Resources available to UMATI were insufficient.

FPSS activities include funding for contraceptive procurement. They also include activity intended to support the MOH assumption of contraceptive logistics responsibilities. These activities include the funding of a logistics officer at the FPU, central warehouse rental, vehicle purchase, improved contraceptive logistics information systems, and nationwide logistics training for district officers. All of these activities have occurred or are currently in process. Specific activities are discussed in following subsections.

10.2 Accomplishments

A comparison of the 1991 and 1994 DHS service delivery modules concludes, "the logistical support to SDPs has increased dramatically."⁴ The authors used two observations to support this conclusion. First, physical checks on the presence of contraceptives at SDPs indicated the availability of injectables, IUDs, and vaginal foaming tablets has doubled during the first three years of FPSS and now approximates the availability of pills and condoms. In 1994 the availability of modern methods typically ranged in the 85 percent to 98 percent range for hospitals, health centers, and even dispensaries. Second, the number of facilities at which staff must travel more than 10 kilometers to pick up contraceptive supplies has been reduced to such a minimal number that the authors chose to list these exceptions as an appendix to the report. Persons contacted during this evaluation were also laudatory in describing the improved availability of contraceptives at SDPs.

10.3 Contraceptive Procurement

Table 10 (page 84) lists FPSS funds already expended and/or obligated for contraceptive procurement in addition to costs for contraceptives to be provided during the remaining three

⁴ Ngallaba, Bardsley, Guilkey and Riphahn, *The Family Planning Service Environment in Tanzania: A Report Based on the 1991 and 1994 DHS Service Availability Modules*, The Evaluation Project, August 1994.

years of FPSS (1995–1997) according Contraceptive Procurement Tables (CPTs). The table predicts a shortfall of approximately \$1.3 million. This table assumes UNFPA rather than FPSS funding will be used for condom procurement during forecasted years.

Since completion of the above-mentioned CPTs, additional information suggests (1) higher than anticipated demand for injectables, and (2) a lower probability of contraceptive oversupply at SDPs. Taking these factors into account, this \$1.3 million figure should be increased to \$2 million.

27. Recommendation: **An additional \$2 million must be added to the contraceptive line item of the FPSS budget to assure adequate funding of contraceptive procurement through the PACD.**

10.4 Warehousing and Distribution

10.4.1 Warehousing

Earlier UNFPA/MOH plans for the construction of a primary health care (PHC) warehouse remain unrealized. FPSS funding, together with funding from the USAID HIV/AIDS prevention project, was used to shift contraceptives from inadequate central storage facilities to acceptable temporary storage. Eventually, scheduled improvements at central medical stores (CMSs) may enable contraceptives to be stored at government expense at CMSs. Regional and district stores will improve as the Institute of Development Management (IDM) logistics training conducts pretraining assessments in each region and district.

10.4.2 Transport

Although the procurement of vehicles has proved one of the more odious administrative tasks undertaken by FPSS to date, it perhaps has arguably led to the most innovative achievement. FPSS has resisted the temptation to adopt a vertical program-specific contraceptive distribution system typical in other sub-Saharan family planning programs. Instead, FPSS has led in the design of an integrated PHC distribution system in which vertical programs such as EPI, EDP, and the National AIDS Control Program (NACP) are able to participate in a single system using common vehicles to move commodities from PHC warehouses to SDPs. This process has been documented in a 1993 written agreement worthy of replication by other national family planning programs.

As modern method contraceptive prevalence increases to many times the level existing at the commencement of FPSS, contraceptive transport requirements will similarly increase. The task of improving supervision also requires additional transport. An additional 10-ton truck to support the movement of contraceptives from the central to regional levels, plus 20 additional double-cab pickup trucks should meet the combined requirements of increasing contraceptive

volume and improved supervision until the PACD. These vehicles should be procured in coordination with the Integrated PHC Transport Committee. Their allocation, maintenance, and the supervision of their use should also support the integrated PHC transport system.

28. Recommendation: **FPSS should procure a 10-ton truck for use in moving contraceptives from the central to regional warehouses and 20 double-cab pickups to support the supervision and contraceptive distribution from the regional level.**

10.5 Logistics Information Systems

The absence of contraceptive stock information continues to plague FPU commodity distribution efforts. The FPSS Project Paper recommendation of adding contraceptive line items to the already operational EDP sentinel commodity reporting system was not implemented. Instead, and belatedly, a temporary mail-back system was implemented. This system reports stock balances and quantities distributed from districts. This temporary logistics management information system (LMIS) now determines quantities to be distributed to districts and supports improved accuracy in the completion of CPTs.

Even information arising from the current temporary LMIS could be better used. Existing information would enable the generation of a single-page report issued quarterly to managerial staff at FPU, USAID, and UNFPA. This report should include for each region:

- Any stock-outs by method at regional stores and the number of stock-outs by method at district stores within the region.
- Estimated number of months supply by method on hand at regional stores and the estimated number of months supply at the average district within the region.

29. Recommendation: **The FPU should produce a one-page contraceptive stock situation report quarterly. This report should be shared with donors.**

The implementation of the full LMIS reporting system has experienced considerable delays. These delays resulted, in part, from efforts to achieve compatibility with the national health management information system (HMIS), the design of which commenced early in the previous decade. Versions of the HMIS that were current during the design of FPSS relied on outdated FP monitoring methodologies. Efforts extending over a two-year period finally produced modifications consistent with minimum reporting practices used by USAID, UNFPA, and IPPF. The revised FP component of the HMIS is now included in the logistics training described below.

10.6 Logistics Training

The FPU and the NACP—with technical assistance from FPLM—has designed a contraceptive logistics system that serves both agencies. This system complies with USAID expectations and is adapted to the individual requirements of Tanzania. The system is documented in the FPU logistics manual. Working from the contents of this manual, a curriculum has been prepared. To better assure institutionalization and sustainability, an in-country organization, the Institute for Development Management, has been selected to provide training for district level personnel. Training occurs by region in a phased manner extending over a 24-month period. Initial training is under way as this evaluation occurred. FPLM's extensive experience with this kind of training suggests it is likely to proceed well during the remaining one year of the FPLM contract. The quality of training during the second year will reflect the extent to which IDM has acquired the requisite skills.

- 30. Recommendation:** **During mid-1995, USAID and the FPU should review IDM's capacity for assuming full responsibility for the remaining logistics training activities.**

11. MANAGEMENT INFORMATION SYSTEMS

11.1 Background

At the commencement of FPSS, family planning service delivery data were collected on an MCH reporting form. One side of these forms includes new acceptors and revisits. The reverse side includes contraceptive commodity data. Use of new acceptor data was constrained by inconsistent definitions of new acceptors. Revisits are a tally of visits rather than clients and, as such, are at best a rough measure of family planning service volume rather than coverage. Districts submit reports monthly to the central level, but reporting was very incomplete and the district data that were submitted included only a few clinics. Reports were stacked in a cardboard box at the MOH, and manual processing was running about three years behind. EPI and EDP had abandoned reliance on the MCH form and had resorted to vertical program reporting. The section on contraceptive commodities was limited to condom and pill distribution. Other methods were not included. Among the districts that did report, only six percent of the forms included any information at all about contraceptive commodities. The remaining 94 percent were blank.

No attempts were being made to revise the MCH format or improve reporting because the MOH had decided to replace these forms with an integrated HMIS reporting system. The HMIS, though, had been held up for years by committee-encumbered design questions. The donor agency funding the HMIS process had abandoned the effort. The family planning section of the proposed HMIS was limited to new acceptors and revisits. Contraceptive commodity data had been deleted.

UMATI contraceptive distribution data included only quantities sent to regions, and even this reflected the *ad hoc* nature of the distribution system. Pre-FPSS attempts to complete CPTs were seriously constrained by this lack of information and relied on USAID and IPPF contraceptive shipment information, but there was little or no information on whether these contraceptives had even arrived in-country, much less how, when, or where they were used.

11.2 Progress and Achievements

Districts no longer submit the MCH form directly to the central level. Instead, regions report monthly, listing data separately for each district. This has diminished the central level aggregation backlog by moving aggregation responsibilities to the regions.

After considerable effort extending over a two-year period, FPSS FPLM technical assistance has succeeded in winning revisions in the family planning portion of the HMIS. It now includes contraceptives dispensed to clients. HMIS has been pilot tested in a district in Mbeya and is implemented, in process, or planned for the remainder of Mbeya region, Iringa, Mutware, Lindi, and Rukwa. These plans, in addition to implementation for the remaining 18 regions, presumes funding will be identified. World Bank funds, originally assumed for the 10 World

Bank districts, have yet to be released. Even if they were released, it would cover about 10 percent of districts.

The IDM/FPLM logistics training will implement—nationwide over the next two years—the family planning sections from the HMIS. As a result, data on contraceptives dispensed to clients will be available nationwide in a phased manner, beginning in Dodoma. This makes the calculation of modern CYP-based indicators of coverage and method mix possible.

The FPU has shown initiative in attempting to use family planning service delivery data. Training has been provided to zonal and regional MCH coordinators. Recent zonal MCH reports include two family planning graphs for each region—one bar graph on coverage and a pie chart on method mix. The FPU intends to begin MIS training for district MCH coordinators in the coming months. The FPU should be commended for initiating training and choosing the two indicators that best fit current programmatic concerns. The FPSS Project has funded and filled an MIS position at the FPU.

11.3 Gaps and Constraints

Remaining problems include the following:

- The project paper provides for 10 person-months of short-term logistics and/or MIS training in the U.S. or a third country. This has not occurred. This remains of use to newly hired logistics staff and officers with MIS responsibilities.
- The coverage and method mix graphs included in the recent zonal reports and FPU training use "continuing users" as a numerator. No reasonable explanation has been provided for the source of this number, but, by deduction, it must be some manipulation of new acceptors and/or revisits. This is not acceptable. The coverage numerator should be CYP. CYP can be calculated in those districts in which either IDM/FPLM or HMIS has introduced the agreed-upon reporting formats.
- The first logistics training of district MCH coordinators is scheduled for Arusha. This region has yet to receive training from either IDM/FPLM or HMIS, therefore it cannot use the CYP concept at this training.
- Three years after HMIS implementation commenced, the HMIS office at the MOH is still unable to provide the MTR team with any reports—even for regions where implementation has occurred. Neither FPSS nor the FPU should assume the HMIS will serve as a service delivery MIS for the NFPP before the end of the project.
- Because no FPU strategy exists for service delivery MIS, MIS instruction is not included in provider training.

11.4 Recommendations

The FPU needs to decide how it is going to achieve a workable MIS based on the CYP MIS technology adopted by USAID, UNFPA, and IPPF. Such technology contradicts nothing in the MOH-approved HMIS, and it builds on the work completed by IDM/FPLM. Such a strategy needs to be documented in a family planning MIS manual that can be adapted into a component of the training curriculum. The easiest way to do this is through study tours to countries within the region where such a CYP-based family planning MIS is operational. Ghana has had a working facility-based CYP family planning information system operational for many years. Botswana, with USAID technical assistance, is currently writing its family planning MIS manual and developing a curriculum.

31. Recommendation: FPU should develop a manual and curriculum for a service delivery information system. Study tours should be conducted to Ghana and Botswana in support of this activity.

Concurrently, FPU should append a service delivery MIS component to IDM/FPLM logistics training. This component should instruct participants in the calculation of CYP-based indicators of coverage and method mix and the in display of these indicators in the manner used by the immunization program. Training should also include suggestions on how these commodity-derived indicators—coverage and method mix—can be used to improve supervision. This must not await completion of the above-mentioned study tours. The study tours will serve to perfect implementation of this training component and support the writing of the family planning service delivery MIS manual.

32. Recommendation: A service delivery MIS component should be appended to the IDM/FPLM logistics training curriculum.

12. MONITORING AND EVALUATION

12.1 Background

As noted in the Project Paper, reliable data for program planning, monitoring, and evaluation were extremely limited at the outset of The FPSS Project. The lack of a national demographic and health survey since 1973 and disputed "official" estimates of fertility levels and growth rates from the 1988 population census compounded the deficiencies in the routine service statistics system described earlier. In view of this, a priority output of FPSS was the development of an information base to support NFPP planning and evaluation.

12.2 Progress and Achievements

A two-prong effort to improve the population/family planning information base has been launched. One thrust, with funding from FPSS, has been an attempt to rehabilitate the routine MOH FP commodities reporting system in support of improved commodities and logistics management. This activity complements efforts funded by other donors to upgrade the broader MIS in the MOH. The specific activities and achievements to date in this area were summarized earlier in this report.

The second initiative, also funded by FPSS, entailed filling short-term information needs with data derived from large-scale national surveys and special studies. These included the Tanzanian Demographic and Health Survey in 1991/2, an interim DHS (the Tanzanian Knowledge, Attitudes, and Practices Survey) in 1994, and a Situation Analysis Study in 1992. A second full-scale DHS, and possibly another SAS, is planned for 1996.

These data collection efforts have been supplemented by timely evaluation/assessment efforts conducted in collaboration with the CAs working in the various areas of program activity (e.g., training, IEC, LT/P methods) and designed to (1) "fill in the gaps" between the large-scale surveys/studies and (2) provide more in-depth information on service delivery system functioning.

The various data sources have been linked under a monitoring and evaluation plan proposed by The EVALUATION Project so as to maximize their utility for program evaluation purposes. The EVALUATION Project views the monitoring and evaluation system adopted by the FPU and USAID/Tanzania (with the exception of the lack of a functioning routine service statistics system) to be a prototype for the effective evaluation of national family planning programs.

It should also be noted that a research and evaluation officer at the FPU has been supported under the project as a first step toward institutionalizing a FP monitoring and evaluation capability within the MOH.

Special note is made of the extraordinarily rapid turnaround time for initial processing of 1994 TKAPS data by the Bureau of Statistics with FPSS assistance while fieldwork was still in progress.

The MTR team views the program indicators developed for the project (Item C1 in the MTR Scope of Work), in particular those in the project logframe, to be less than optimal. The team recognizes that the indicators were developed at a time when information on the family planning situation in Tanzania was in short supply but feels that the improved information base that the project has helped to develop justifies a re-examination of these and the development of new indicators that provide a more meaningful basis for monitoring accomplishments over the remainder of the project.

On the other hand, the data bases that have been developed to date under the project have a sound basis and have effectively filled many of the information gaps that existed at the outset of the project. With the exceptions of limited use of data from the SAS (some/many of whose findings seem to have been disputed) and few secondary analyses of the 1991/2 TDHS having been undertaken, information from the data bases developed under the project to date have been meaningfully used to enhance program planning and implementation.

With regard to the use of results of assessments and evaluations to adjust program activities, many of the significant assessment/evaluation efforts undertaken to date have been conducted within six months of the MTR, so observations should be viewed as tentative. The available evidence suggests however, that assessments/evaluations of project training, IEC, CBD, and management enhancement efforts have been or will be used in meaningful ways. In the case of training, adjustments have been made on an ongoing basis in response to feedback from individual training sessions. In the absence of routine data systems, the MTR team views the midterm assessments conducted for the different areas of program activity as vital for effective program monitoring and evaluation.

12.3 Gaps and Constraints

A major gap in information support to program monitoring and evaluation continues to be the lack of a reliable routine service statistics system. Activities are underway to correct this problem.

Even if efforts in this area are successful, however, information on the quality of service delivery on a periodic basis and findings from operations research on key strategic and operational issues and problems will be needed as the program moves from the takeoff to the expansion and consolidation phases of program development.

Program strategic planning might also benefit from taking greater advantage of the significant survey data that have been accumulated. While the survey data have provided general parameters for program planning, the potential for acquiring a deeper understanding of "the market" for family planning services has not been exploited. Further analyses of (1) the structure of demand and unmet need for family planning services and the extent to which

these have changed over the project period, (2) factors underlying contraceptive method choices, and (3) levels and causes of contraceptive discontinuation (using "current-status" methods) would seem to be particularly worthwhile at the program's current stage of development.

Finally, because of limited staff capacity at the central level (in terms of numbers), a stronger FPU field presence is needed. Here, initiatives that push some of the routine program monitoring functions down to the field level are worthy of consideration. The proposal to emphasize and strengthen use of commodities data at the SDP and district levels for routine program monitoring made in the previous chapter is illustrative of this approach. The weak field-level supervision noted in the Project Paper has to date only been addressed at the margins, and the supervisory initiative under the AVSC project is only an interim measure. A stronger linkage of routine supervision and information gathering and use "on the front lines" might be an effective way to address both problems. This would, however, require further investments in supervisory training and logistical support in the form of transportation and per diem allowances.

12.4 Recommendations

- 33. Recommendation:** The FPU should actively participate in and support the implementation of the new commodities/logistics reporting system and HMIS in order to expedite their full implementation. Until a reliable routine system is in place, the ability of the FPU and USAID to track program outputs on a timely basis will remain limited.
- 34. Recommendation:** Operations research in support of program expansion should be activated as soon as possible, making sure that FPU and MOH staff members are active participants in such studies to ensure that study findings are incorporated into subsequent program decision making.
- 35. Recommendation:** Further initiatives to improve the utilization of data for program monitoring should focus on the field level, because data use at this level is likely to have the most immediate payoff in terms of improved service delivery. Should USAID decide to support further interventions in improving program supervision, part of any such initiatives should be the use of routine service statistics at the SDP and district levels.
- 36. Recommendation:** USAID should schedule another round of evaluations and/or assessments for program activity areas, such as those undertaken prior to the MTR, to be available for the final project evaluation. These data, when used in combination

with data from the series of large-scale surveys, should provide a rich data basis for the design of a follow-on project.

37. Recommendation: Another Situation Analysis Study should be conducted at about the same time as the next full-scale DHS in order to provide detailed information on the nature and magnitude of improvements in service delivery system functioning. In order to be of maximum utility for program evaluation purposes, the SAS should be undertaken in the same sample areas/clusters as the DHS.
38. Recommendation: FPU and USAID should encourage, facilitate, and, as feasible, participate in secondary analyses of the TDHS and TKAPS on topics relevant to NFPP program functioning and strategic planning.

13. SPECIAL ISSUES

In undertaking this evaluation, a number of issues arose which the MTR team viewed as critical to the area of reproductive health in Tanzania. These issues—adolescents, STDs/HIV, abortion/post-abortion care, and refugees—are not referred to directly within the FPSS but fall under the purpose of the project and of USAID/Tanzania's Strategic Plan. These issues have recently been articulated by USAID/Washington as areas of concern for USAID worldwide and deserve focus within FPSS activities.

13.1 Adolescents

The age distribution of the Tanzanian population illustrates an increasing emergence of a very young population. Currently, 46 percent of the population is below the age of 15. The 1991 TDHS reflects that the average age of marriage is 16 and 60 percent of women have had a birth or are pregnant by age 19. The TDHS also reports that 27 percent of youths have their first sexual experience prior to age 15.

Although young people are sexually active, they have difficulty obtaining accurate reproductive health information and appropriate services. Many health providers refuse to counsel and provide adolescents with family planning services. Most adolescents are afraid or embarrassed to obtain information or services at health facilities where they may see relatives or acquaintances who do not accept the fact that they are sexually active.

Due to the high incidence of unwanted pregnancy, women suffer from a high rate of morbidity and mortality from attempted abortion. Young women also die more frequently in birth because their bodies are not physically mature for childbirth. Youth in general have high rates of STDs and death due to AIDS.

To reach adolescents with accurate health information, IEC messages and services should be targeted to their needs. The MOH has become cognizant of the needs of this population and FPSS has addressed this issue in some of the provider training. Social marketing of pills will also assist. However, more focus should be placed on improving information and services for youth.

The fertility of young people carries the potential for a major impact on the future population size of the country.

39. Recommendation: **USAID and FPU should integrate appropriate IEC and service interventions targeting youth into the FPSS program. Training to improve the attitudes and practices of service providers toward youth should be a particular emphasis.**

13.2 STDs/HIV

The Mission has responded to the high incidence of STDs/HIV with the 1994 Tanzania AIDS Project (TAP) (\$20 million). However, within FPSS, other measures could be undertaken to provide STD education and services that could improve reproductive health and family planning service quality. Suggestions include (1) training all CBD workers in STD/HIV counseling and education; (2) strengthening the training of health providers in STD/HIV service provision; (3) linking the provision of STD drugs with FPSS trained providers; and (4) strengthening referral systems between STD treatment sites and family planning service provision at all levels.

- 40. Recommendation:** **FPU and USAID (Health, Population, and Nutrition and TAP staff) should meet to review where STD/HIV education and service provision should be strengthened within The FPSS Project.**

13.3 Abortion

As in many countries, accurate statistics on abortion are few (because it is illegal and the stigma connected with abortion is strong), yet, abortion appears to be widely practiced. Although the issue is still sensitive in the country, the MOH recognized the medical, social, and legal problems associated with abortion and in 1991–92 requested UMATI to undertake several studies on abortion.

From the UMATI studies, it is estimated that there are 4,000–5,000 maternal deaths in Tanzania, 50 percent of which are due to complications of abortion. A high percentage of women seeking abortion are under the age of 16. One study based on hospital data indicated that 33 percent (or higher) of all admissions to obstetrics and gynecology wards were the results of unsafe abortions. As in most countries where abortion is illegal, hospital data document only a small proportion of deaths and morbidity from abortion complications. Most women die outside hospitals in rural or urban areas with no health care.

Further research is needed to assess the magnitude of the problem in Tanzania and actions that should be taken.

- 41. Recommendation:** **USAID and FPU should commission an assessment by the International Projects Assistance Services (IPAS) that would look at the need for training and equipping providers to safely treat complications from abortion and providing post-abortion counseling and family planning services. If it is determined that need exists, the assessment should be followed by an action plan and the appropriate interventions.**

- 42. Recommendation:** **USAID should provide technical assistance to FPU to utilize The RAPID Project to raise awareness related to the high mortality and morbidity due to abortion (and adolescent fertility).**

13.4 Refugees

Due to civil war in Rwanda, a large number of refugees have flowed into northern Tanzania. The United Nations High Commission on Refugees (UNHCR) estimates the total refugee population in Tanzania to be 510,000. Due to the high incidence of HIV in Rwanda, there is strong concern that the influx of refugees could greatly accelerate the transmission of HIV. Additionally, studies of refugee populations report very high fertility rates (7.0) due to the high incidence of rape and unwanted sex; lack of access to food and maternal care services; and lack of family planning information and services.

The African Medical and Research Foundation (AMREF) and CARE are providing AIDS and reproductive health care services in the Ngara. However, neither agency has been willing to provide services in one area (Karagwe) due to the poor infrastructure and scattered population. CARE is distributing condoms with AIDSCAP support (approximately \$1 million). FPU has provided 6,000 vials of Depo-Provera to the International Red Cross. UNFPA donated Microgyn (100,000 cycles), Microlute (2,500 cycles), Delfen Foam (1,250), Depo-Provera (8,000), and IUDs (250) to UMATI for the refugee population.

- 43. Recommendation:** **USAID (in cooperation with UNHCR) should follow the refugee situation and work with FPU and UMATI to provide contraceptives (and condoms for HIV protection) if the need arises.**

14. SUSTAINABILITY

14.1 Background

The FPSS Project Paper took the long view of project sustainability. It predicated sustainability on an ever-increasing governmental and political level, in addition to budgetary commitment to family planning in response to rising popular demand over a 20-year period. In particular, a sustainable program was viewed as one which is largely reliant on internal rather than external resources, financial as well as non-financial. During the seven-year life of FPSS, it was expected that a number of things would occur which would contribute to the longer-term sustainability of Tanzania's family planning program:

- A marked increase in individual families' desire for child spacing would occur.
- Donor support for the expansion of the family planning program would increase as donor coordination improves (with USAID playing an activist role), and the donors would develop a greater appreciation for Tanzania's commitment to effective service delivery.
- Tanzanian institutions would be strengthened to significantly reduce the amount of outside technical assistance and financial resources necessary to sustain family planning activities.
- Studies and analyses would be conducted that identify governmental budget requirements and the relevant policies and procedures governing such requirements as staff, fees, and the role of the private and NGO sectors in family planning service delivery.
- The government would develop cost information for the delivery of family planning services and develop approaches for introducing methods of cost recovery and project sustainability (this was a Project Paper covenant).
- A sustainability strategy would be developed.

14.2 Progress and Achievements

As addressed in many of the other sections of this review, considerable progress has been achieved in a number of areas in reaching the sustainability objectives of FPSS:

- The FPU staff and NFPP operations have been fully integrated into the MOH structure financially, logistically, and managerially (with MOH MCH staff being trained to deliver FP services; the FPU funding cycle now coinciding with that of the GOT's fiscal year; the Tanzania controller and auditor general having

responsibility for auditing the FPSS grant to FPU; and NFPP using the same logistics and reporting system as the rest of the MOH).

- FPU capabilities have been strengthened in the management of the family planning program.
- USAID donor coordination efforts have resulted in all donors which provide contraceptives using a common set of Contraceptive Procurement Tables to prevent duplication and enhance cost effectiveness.
- The government has recently introduced a scheme of cost sharing (user fees) for curative services, with 100 percent of revenue being retained by the facilities for their discretionary use.
- Pilot activities are under way in the private sector that should provide models for increasing the proportion of family planning services being provided through private sector channels and help reduce the financial burden on the public sector.
- Pilot activity is under way (Pathfinder/SDA CBD project) that is testing a user fee scheme for family planning services.
- Awareness of the importance of supporting family planning is being raised at the regional and district levels through RAPID and FAMPLAN presentations.
- A dramatic increase in utilization of modern family planning methods, which are more effective, as well as an overall shift in method mix to longer-term methods, which are more cost-effective over the long term.

14.3 Gaps and Constraints

An analysis conducted by the REDSO/East and Southern Africa (ESA) health economist in November 1993 pointed out that the ability of Tanzania to support family planning and other preventive services is extremely limited due to the following factors:

- Total health expenditure in the country is only around \$1 per person.
- Only 5.2 percent of national health expenditures and 3 percent of regional health expenditures go toward preventive services.
- Preventive services are largely supported by donors, including recurrent costs related to these services, while the bulk of government funding continues to go toward curative services.

Given the state of the economy and the requirements of the structural adjustment program, it is unlikely that government funding for the health sector will increase substantially any time soon or will be able to support the foreign exchange costs of the health program. Therefore, without a substantial shift in the proportion of funding devoted to preventive versus curative services, there is little likelihood that preventive services can become fully sustainable without donor support in the near future.

While managerial and technical sustainability have been considerably enhanced through capacity building and training of service providers, this capacity is far from sufficient to sustain the family planning program. Even with accelerated training of family planning service providers and related personnel in both the public and private sectors, it will be many years before there will be institutionalized management, technical, and training capacities needed to sustain the family planning program without some degree of outside assistance.

While awareness of the importance of family planning may be developing at the regional and district levels, according to the MOH, this awareness has yet to be translated into a higher priority being afforded to family planning for available funding. Also, there has been little institutionalization of family planning management capabilities at these levels. These capabilities must be developed as an integral part of broader regional and district planning, budgeting, and management if they are to be sustainable. This does not appear to be happening.

The private sector appears to offer potential for assuming an increasing proportion of the burden entailed in providing family planning services. This potential, however, must be developed and this will take resources and time if the private sector is to have the capability to deliver the quality services needed to help support a sustainable family planning program. The government's review of licensing requirements for private sector providers, which is expected to lead to a proliferation of private clinics, is a major step in the direction of realizing this private sector potential, but this must be approached cautiously to ensure that standards of service quality are maintained.

Although the government does not have a stated strategy for sustaining family planning (and other preventive services), it obviously is proceeding in the right direction. Such a strategy, if developed in conjunction with major donors, would be very useful at this time to chart the way for the achievement of a sustainable family planning program.

14.4 Recommendations

- 44. Recommendation:** **FPSS should continue to support capacity building at the central level in family planning program management, service provision, IEC, and logistics and work to extend this capacity building down to the regional and district levels.**

- 45. Recommendation:** FPSS should support an assessment of the various options for sustainability and a workshop for development of a national strategy for achieving a sustainable family planning program. This activity could be handled through a buy-in to The OPTIONS Project for approximately \$100,000.
- 46. Recommendation:** USAID/Tanzania should work with other major donors to the health sector to develop a strategy to convince the government of the need to allocate a larger share of health funding for preventive services.
- 47. Recommendation:** The FPU and USAID/Tanzania should work to diversify the funding base for the NFPP and in particular, increase the range of donors so that the public sector program is not overly dependent on one or two major donors, as is currently the case, and expand the involvement of the private sector.
- 48. Recommendation:** FPSS should support the steps to institutionalize preservice training to ensure that an established structure exists to train high-quality health providers from the onset (instead of relying only on in-service training).

15. GENERAL RECOMMENDATIONS

As part of its Scope of Work, the MTR team was asked to consider whether or not The FPSS Project should be amended, and, if so, to make recommendations regarding changes in project emphases, possible additional time and resource requirements, and other cross-cutting issues.

All team members participated in a review of each aspect of The FPSS Project being evaluated and, as a team, reached agreement on specific recommendations regarding what should be done to achieve objectives in each area (i.e., training, IEC, etc.). Based on overall team findings the MTR recommends the following:

- **Additional Financial Resources.** For most components of the project, additional financial resources and technical assistance will be required to continue progress toward attainment of FPSS objectives. The MTR team estimated that approximately \$8.3 million will be required to maximize achievement and impact in all project areas through to current PACD.
- **Project Extension.** While additional time beyond PACD was not considered necessary for achievement of currently stated project objectives, the team recommended that consideration be given to extending the project for two to three years in order to better institutionalize the capacity being developed in both the public and private sectors for family planning program implementation. In addition, because of the fact that (most likely) there will not be a major shift in project direction, the team also recommends:
 - * **Updating Indicators.** Many of the indicators do not measure the outputs precisely or are very gross measures. As there are now sufficient information and data available to more precisely measure project progress, indicators and targets of achievement should be updated and more specifically defined for the remaining period of the project (with reference to the work on monitoring and evaluation undertaken by Rutenberg and Magnani in February 1993).
 - * **Developing a More Detailed Implementation Plan.** While the project design is basically sound and redesign is not required, an updated logframe showing refined indicators of performance and a more detailed implementation plan should be developed for the remaining period of the project.

Implementing these recommendations will entail a Project Paper supplement. Extrapolating from current and recommended levels of expenditures, costs of an extension would require approximately \$4.0 million per year.

TABLE 2.1

SUMMARY OF PROJECT PURPOSE ACCOMPLISHMENTS	
PROJECT PURPOSE: INCREASE CONTRACEPTIVE ACCEPTANCE AND USE	
INDICATOR	STATUS
A cumulative increase in contraceptive prevalence of one percent per year beginning in year two.	CPR (modern methods) increased from seven to 16 percent between 1991 and 1994; prevalence for all methods increased from 10 to 24 percent during this period.
A 50 percent increase in the number of acceptors returning for supply.	New acceptors increased 40–50 percent between 1991 and 1994; monthly resupply client visits rose 23 percent.
A doubling of the number of Tanzanians who are aware of family planning and know at least one modern method of contraception.	As of mid-1994, 79 percent of women of reproductive age and 90 percent of men knew at least one modern contraceptive method (over 90 percent of both men and women in Dar es Salaam).

TABLE 2.2

SUMMARY OF PROJECT OUTPUT ACCOMPLISHMENTS			
OUTPUT # 1: DELIVERY OF QUALITY FAMILY PLANNING SERVICES EXPANDED			
Indicator	Status	Recommendation	Resources
1.1 Majority of MCH Centers and at least 20 private or parastatal health facilities with access to long-acting methods of contraception, including voluntary sterilization.	Majority of MCH hospitals, health centers, and dispensaries offer orals, injection, condoms, and foam - with these methods in stock. 88 percent of MOH hospitals offer TLs; 43 sites are supported by VSC. Diversification of method mix includes an increased reliance on injection and IUDs.	Extend AVSC activities from 1995 completion through 1997	\$2,000,000
	Private Sector/ NGO clinical services: UMATI LT&P methods at 43 sites extending to 70; Marie Stopes expanding LT&P methods from four to 12 private sector sites; Pathfinder /OTTU expanding LT&P methods to 26 work sites.	Assessment of private sector leading to development of strategy / action plan for FP expansion.	\$ 100,000 buy-in to OPTIONS or equivalent for assessment; \$20,000 workshop for strategy development.
		Additional pilot projects initiated: <ul style="list-style-type: none"> • social market'g OC & depo • CMBT • Medical Associations 	funds for pilot schemes: SM = \$500,000 CMBT = \$500,000 MED = \$100,000
1.2 Reliable national contraceptive supply, distribution, and reporting system.	Contraceptive availability at SDPs significantly improved; Availability at health centers have increased for injectables from 34 percent to 90 percent and at dispensaries from 20 percent to 84 percent; for IUDs comparable figures are from 18 percent to 55 percent, and 13 percent to 25 percent. Logistics training is at an early implementation stage at time of MTR. Temporary mailback system in place during implementation.	Provide funds for adequate contraceptives. Additional funds required in line item to assure contraceptives through PACD.	US \$2 million through current PACD
		More transport capacity is required to support distribution from central to regions.	\$80,000

OUTPUT # 2: TANZANIAN INSTITUTIONAL CAPACITY ENHANCED.			
Indicator	Status	Recommendation	Resources
2.1 An ongoing system for pre- and in-service training for supervisors and providers, with instructors and FP providers trained in a majority of districts.	Preservice training curriculum developed but not implemented.	FP preservice curricula should be implemented.	workshop = \$50,000
	Delay in implementation in training; INTRAH trained 267 out of targeted 752, development of CTT and 5 RTTs; trng materials and curricula developed and disseminated; VSC exceeded targets	Accelerate in-service training	\$2.5 million for training & equip beyond 03/95, plus an additional \$700,000 for vehicles and maintenance.
		Provide Supervisory training and 20 additional vehicles	
		Provide FP clinic equip	
		Expand VSC training	included in 1.1
2.2 FP informational materials for managers, providers, and clients available at a majority of FP sites.	Over 2.5 million pieces of IEC materials have been produced but distribution has been limited to 7 districts and 22 SDPs; program is not yet nationwide. Radio programming has also been developed and aired. The Logo has been developed, tested and is widely distributed.	Material production and distribution needs to be expanded and accelerated, including via CBD networks.	
2.3 Sustainability strategy developed.	There is no articulated sustainability strategy; but initiatives have been taken to move toward sustainability (e.g. demand generation, private sector involvement, decentralization)	The FPU should develop sustainability strategy.	\$ 100,000 buy-in to OPTIONS for assessment and workshop for strategy development.
		USAID should strengthen private sector activity	
		FPU and USAID should influence other donors to support family planning /population activity	
	FPU has greatly expanded their capacity to manage, coordinate and implement NFPP.	Sustain and strengthen this capacity.	additional \$ 2.4 million required prior to current 12/97 PACD

OUTPUT # 3: INFORMATION BASE DEVELOPED.			
Indicator	Status	Recommendation	Resources
3.1 An ongoing process of providing information on key FP issues to national, regional, and local leaders, and opinion makers is in place.	System to provide information on basis of regularly scheduled surveys and special studies is in place; RAPID program for raising awareness implementing when opportunities occur at national level.	Program and large scale survey should continue.	\$900,000 for DHS and \$500,000 for Situation Analysis
		RAPID presentation should be continued systematically at district and regional as well as at national levels.	\$150,000
		Operations research and program related analysis of DHS data should begin ASAP.	none required
3.2 A functioning MIS provides information for decisions about FP planning, policy, priorities, resource allocation, and sustainability.	FPSS funded LMIS in early stage implementation. Integrated MOH/HMIS also at early stage implementation. Two year phase-in period required. Both systems use common FP formats.	FPU should develop FP service delivery reporting system manual and curricula via structured study tours.	none required
		A FP service delivery reporting component should be added to LMIS training curriculum.	none required

TABLE 2.3

COMPARISON OF SELECTED FACILITY-BASED OUTCOME INDICATORS, 1991/2 AND 1994 DHS SERVICE AVAILABILITY MODULES¹		
CATEGORY/INDICATOR	1991/2	1994
Facility Infrastructure		
<u>Median number of beds:</u>		
Hospitals	150	160
Health Centers	22	26
Dispensaries	3	2
<u>Percent with electricity:</u>		
Hospitals	91	86
Health Centers	26	27
Dispensaries	20	21
<u>Percent with running water:</u>		
Hospitals	88	81
Health Centers	55	43
Dispensaries	39	31
Presence of Trained Staff		
<u>Percent with doctors trained in family planning:</u>		
Hospitals	75	73
Health Centers	--	--
Dispensaries	--	--
<u>Percent with medical assistants trained in family planning:</u>		
Hospitals	38	41
Health Centers	46	54
Dispensaries	--	--
<u>Percent with nurses trained in family planning:</u>		
Hospitals	78	80
Health Centers	51	44
Dispensaries	23	14
<u>Percent with MCH aides trained in family planning:</u>		
Hospitals	83	75
Health Centers	76	82
Dispensaries	83	79
<u>Percent with rural aides trained in family planning:</u>		
Hospitals	17	11
Health Centers	40	23
Dispensaries	53	49
<u>Percent with doctors trained in IUD insertion:</u>		
Hospitals	84	73
Health Centers	--	--
Dispensaries	--	--
<u>Percent with medical assistants trained in IUD insertion:</u>		
Hospitals	36	45
Health Centers	--	--
Dispensaries	--	--

**COMPARISON OF SELECTED FACILITY-BASED OUTCOME INDICATORS,
1991/2 AND 1994 DHS SERVICE AVAILABILITY MODULES (CONTINUED)¹**

CATEGORY/INDICATOR	1991/2	1994
Presence of Trained Staff		
<u>Percent with nurses trained in IUD insertion:</u>		
Hospitals	69	67
Health Centers	33	38
Dispensaries	8	9
<u>Percent with MCH aides trained in IUD insertion:</u>		
Hospitals	56	58
Health Centers	45	60
Dispensaries	40	44
<u>Percent with rural aides trained in IUD insertion:</u>		
Hospitals	5	9
Health Centers	17	17
Dispensaries	24	28
Service/Contraceptive Availability		
<u>Percent offering oral contraceptives:</u>		
Hospitals	97	100
Health Centers	99	100
Dispensaries	98	99
<u>Percent offering injection:</u>		
Hospitals	91	100
Health Centers	42	91
Dispensaries	23	84
<u>Percent offering IUD:</u>		
Hospitals	94	97
Health Centers	24	55
Dispensaries	15	27
<u>Percent offering condoms:</u>		
Hospitals	95	95
Health Centers	97	92
Dispensaries	98	97
<u>Percent offering foam:</u>		
Hospitals	54	76
Health Centers	24	71
Dispensaries	16	50
<u>Percent offering sterilization:</u>		
Hospitals	88	88
Health Centers	--	--
Dispensaries	--	--

**COMPARISON OF SELECTED FACILITY-BASED OUTCOME INDICATORS,
1991/2 AND 1994 DHS SERVICE AVAILABILITY MODULES (CONTINUED)¹**

CATEGORY/INDICATOR	1991/2	1994
Contraceptive Supply		
<u>Percent with oral contraceptives in stock:</u>		
Hospitals	92	98
Health Centers	83	94
Dispensaries	84	96
<u>Percent with injection in stock:</u>		
Hospitals	84	97
Health Centers	34	90
Dispensaries	20	84
<u>Percent with IUDs in stock:</u>		
Hospitals	84	97
Health Centers	18	55
Dispensaries	13	25
<u>Percent with condoms in stock:</u>		
Hospitals	82	89
Health Centers	97	82
Dispensaries	97	87
<u>Percent with foam in stock:</u>		
Hospitals	45	75
Health Centers	19	66
Dispensaries	11	46
<u>Percent that must pick up supplies:</u>		
Hospitals	14	8
Health Centers	13	11
Dispensaries	26	22
Service Volume		
<u>Mean monthly number of new acceptors:²</u>		
Hospitals	37	55
Health Centers	12	27
Dispensaries	17	15
<u>Mean monthly number of resupply clients:²</u>		
Hospitals	122	205
Health Centers	47	54
Dispensaries	33	36

Source: Ngallaba et al., 1994.

¹ Data shown are for 366 facilities (80 hospitals, 85 health centers, and 201 dispensaries) visited in both the 1991/2 and 1994 surveys. The facilities were the nearest of each type to DHS sample clusters.

² Service statistics are for the 12 months preceding the respective surveys.

TABLE 2.4

COMPARISON OF SELECTED INDICATORS, 1991 AND 1994 FAMILY PLANNING COMMUNICATION PROJECT KNOWLEDGE, ATTITUDES AND PRACTICES SURVEYS ¹		
CATEGORY/INDICATOR	1991/2	1994
Knowledge of Family Planning Methods		
<u>Percent with spontaneous knowledge of any modern method:</u>		
Women (n=788 in 1991 and 784 in 1994)	70	78
Men (n=803 in 1991 and 790 in 1994)	67	77
<u>Percent with assisted knowledge of any modern method:</u>		
Women	89	97
Men	81	81
<u>Percent with spontaneous knowledge of any traditional method:</u>		
Women	35	14
Men	33	15
<u>Percent with assisted knowledge of any traditional method:</u>		
Women	83	81
Men	81	81
Percent Disagreeing with Selected Misperceptions and Rumors Regarding Family Planning		
<u>FP makes women promiscuous</u>		
Women	52	52
Men	53	64
<u>FP causes conflict among spouses</u>		
Women	49	49
Men	51	62
<u>FP is against God's will</u>		
Women	40	50
Men	47	56
<u>FP causes infertility</u>		
Women	43	47
Men	42	43
<u>FP makes men jealous</u>		
Women	25	25
Men	40	48
<u>FP can get lost in the womb</u>		
Women	25	22
Men	23	21

Source: Jato and Mbago, 1994.

¹ Due to time constraints, data limited to three regions: Dar es Salaam, Kisarawe, and Mwanga.

TABLE 2.5

TABLE 2.6

COMPARISON OF SELECTED POPULATION-BASED OUTCOME INDICATORS FOR TWO REGIONS AND TANZANIA AS A WHOLE, 1991/2 TDHS AND 1994 TKAPS						
CATEGORY/INDICATOR	DAR ES SALAAM		MWANZA		TANZANIA ¹	
	1991	1994	1991	1994	1991	1994
No. currently married women (n)	349	272	444	238	6038	2716
Contraceptive Awareness						
<u>Pct. knowing any modern method:</u>						
All women	--	92	--	69	72	78
Currently married women	91	97	75	71	78	82
<u>Pct. currently married women knowing:</u>						
Pill	--	97	--	62	75	78
IUD	--	88	--	33	35	52
Injection	--	92	--	48	44	68
Diaphragm/foam/jelly	--	45	--	28	22	30
Condom	--	94	--	59	55	71
Female sterilization	--	69	--	47	55	62
Male sterilization	--	16	--	15	11	19
Exposure to Family Planning Messages						
<u>Percent of all women who have heard family planning message(s) on:</u>						
Radio only	53	77	22	42	22	54
TV only	1	1	*	*	*	*
Both	2	16	*	3	1	7
Neither	44	7	77	55	76	39
Contraceptive Use						
<u>Percent of currently married women currently using:</u>						
Any method	16	32	4	17	10	24
Any modern method	11	22	2	7	7	16
Pill	6	10	2	3	3	6
IUD	1	1	0	*	*	2
Injection	1	6	0	2	*	4
Diaphragm/foam/jelly	0	0	0	0	0	*
Condom	2	1	0	*	1	2
Female sterilization	2	4	1	1	2	3
<u>Percent of currently married women currently using a modern method with public sector source of supply:</u>	--	66	--	67	73	69

**COMPARISON OF SELECTED POPULATION-BASED OUTCOME INDICATORS FOR
TWO REGIONS AND TANZANIA AS A WHOLE, 1991/2 TDHS AND 1994 TKAPS
(CONTINUED)**

CATEGORY/INDICATOR	DAR ES SALAAM		MWANZA		TANZANIA ¹	
	1991	1994	1991	1994	1991	1994
Desire for Children						
<u>Percent wanting:</u>						
No more children	--	25	--	15	21	25
Another child within 2 years	--	26	--	30	26	22
Another child after 2 years	--	32	--	40	42	40
Another child, timing uncertain	--	*	--	5	1	2
Undecided	--	11	--	5	3	5
<u>Demand for Family Planning</u>						
Pct. with demand for FP, total	50	55	31	37	41	52
Pct. with demand for limiting	22	26	13	10	17	22
Pct. with demand for spacing	27	30	18	27	24	30
Pct. with unmet need, total	34	23	27	21	30	28
Pct. with unmet need, limiting	14	9	11	6	12	1
Pct. with unmet need, spacing	20	14	16	15	18	17
Pct. of total demand satisfied	32	58	13	44	26	46
Pct. of demand for limiting satis.	38	64	16	44	27	51
Pct. of demand for spacing satis.	27	53	19	45	25	43
Future Contraceptive Intentions						
<u>Percent of currently married women not currently using a method intending to:</u>						
Use within 12 months	--	32	--	36	19	36
Use later	--	21	--	19	6	16
Use, unsure as to timing	--	4	--	2	2	2
Unsure as to intentions	--	17	--	11	17	11
Not use	--	23	--	33	60	34

Note: percentages may not add to 100 due to rounding and missing data.

¹ Estimates are weighted estimates based upon a partial sample of n = 100 out of n = 203 clusters, and should be viewed as preliminary.

-- Requires special tabulation of 1991/2 data.

* Less than one-half of one percent.

TABLE 7.1

SUMMARY OF NUMBERS TRAINED VS. TARGETS			
TYPE OF TRAINING	# TRAINED		TARGETS
	1991 BASELINE	1994 TO DATE	
FPU			
FP Orientation	0	315	NA
Comprehensive Clinical Skills	0	120	NA
INTRAH			
Comprehensive Clinical Skills	0	229	317
Preceptors INTRAH	0	19	30
Basic Training INTRAH	0	77	83
Supervision INTRAH	0	68	120
Reproductive Health INTRAH	0	115	216
UMATI			
ML/LA Surgeons	14	84	36
ML/LA Assistants	14	71	NA
Counselors	21	158	101
NORPLANT® Surgeons	1	8	4
No-Scalpel Vasectomy Surgeons	1	5	6
Postpartum IUD Insertors	0	1	NA

TABLE 7.2

SEATS		
TYPE OF TRAINING	TRAINING INSTITUTE	TRAINEES
IEC	JHU/PCS	4
Management of Training	University of Connecticut	2
Contraceptive Technology Update	CAFS, Nairobi	2
Clinical Procedures	INTRAH, Kenya and Uganda	24
CBD Study and Observation Tour	SEATS, Kenya	9
FP Management Course	SEATS, Dar es Salaam	13
Computer Applications	SEATS, Dar es Salaam	6
Training Conference	SEATS, Nairobi	3

TABLE 10

Contraceptive Procurement Financing FPSS LOP⁵	
FPSS contraceptive LOP budget	\$4,257,000
Contraceptives procured (1994 inclusive)	\$2,829,000
CPT 1995 forecast	\$781,046
CPT 1996 forecast	\$956,604
CPT 1997 forecast	\$992,642
TOTAL	\$5,559,292
LOP predicted deficit	(\$1,302,292)

⁵ The Contraceptive Procurement Tables break the annual cost figures into shipments. Each forecasted shipment specifies shipment date, brand, donor, and quantity to be shipped. 1997 forecasted shipments were costed at 1996 prices.

APPENDICES

APPENDIX A

MIDTERM REVIEW TEAM MEMBERS

Merrill M. Shutt, M.D., M.P.H.	Team Leader, POPTECH Associate Professor, University of North Dakota School of Medicine, Department of Community Medicine and Rural Health
Anne Fleuret, Ph.D.	Impact Assessment Advisor, USAID/Tanzania
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Ray Kirkland, Ph.D.	Regional Population Development Officer, USAID/REDSO/ESA, Nairobi, Kenya
Robert J. Magnani, Ph.D.	Assistant Professor, Tulane University School of Public Health and Tropical Medicine. Evaluation Specialist, The EVALUATION Project
Nimrod Mandara, M.D.	Private Consultant, Dar es Salaam, Tanzania
Gottlieb Mpangile, M.D.	Director of Programs, Tanzania Family Planning Association (UMATI), Dar es Salaam, Tanzania
Clifford D. Olson, M.A.	Private Consultant, POPTECH
C.K. Omari, Ph. D.	Professor of Sociology, University of Dar es Salaam, Dar es Salaam, Tanzania
Willa Pressman, M.P.H.	Regional Coordinator, USAID/Washington
Susan Ross, B.S.N., M.P.H.	Population Advisor, USAID/Nigeria
Joyce Safe, R.N.M., Advanced Dip.	Principal Nursing Officer, Ministry of Health, Dar es Salaam, Tanzania

APPENDIX B

LIST OF PERSONS INTERVIEWED

Washington, DC

USAID

Allen Brimmer, Tanzania Country Specialist, Office of Population

Margaret Neuse, Deputy Director, Office of Population

John Snow, Inc.

Steve Perry, Family Planning Logistics Management (FPLM) Project

Melinda Ojermark, Acting Regional Director, East and Southern Africa, Service Expansion and Technical Support (SEATS) Project

Dar es Salaam

USAID/Tanzania

Mark Wentling, Mission Director

William Anderson, Deputy Mission Director

Dana Vogel, Health, Population and Nutrition Officer

Dr. F.M. Mburu, Senior Population Program Specialist

Michael Mushi, Assistant Health, Population and Nutrition Officer

Susan Hunter, AIDS Advisor

Paul Morris, Program Office

John Hepp, Controller

Ministry of Health

Dr. F.H. Mrisho, Assistant Chief Medical Officer, Preventive Services

Dr. Calista Simbakalia, Director, Family Planning Unit

Dr. Catherine Sanga, Deputy Director for Service Delivery, Family Planning Unit

Peter Riwa, Research and Evaluation Officer, Family Planning Unit

Mrs. Joy Bategareza, Training Program Officer, Family Planning Unit

Mrs. T. Tibaijuka, Training Officer, Family Planning Unit

Ms. Neema Mushi, Storekeeper, Family Planning Unit

Mrs. Subira Kiluvia, Health Education Unit

Peter Kasoni, Training Department-Nursing Section

Tanzania Family Planning Association (UMATI)

Dr. N. Katunzi, Executive Director

Dr. A.D. Rukonge, VSC Coordinator

Ms. Grace Naburi, CBD Coordinator

Bureau of Statistics

Sylvester Ngallaba, Director

United Nations Population Fund (UNFPA)

J. Bill Musoke, Country Director

Dorothy Temu, National Programme Officer

United Nations Children's Fund (UNICEF)

Dr. Rosemary Kigadye

World Bank

Charles Griffen, Population-Health-Nutrition Tanzania Technical Assistance Manager

Mr. Paul Shaw, Public Health Specialist, Africa

Overseas Development Agency (ODA)

Steve Crossman, Country Director

Prof. Hillary Homans, Population-Health Technical Specialist

JICA

Kiyoshi Hirakawa, Resident Representative

GTZ

Dr. Richard Rohde, Family Health Programme Director

Ms. S. Mlay, Family Planning Coordinator

Macro International, Inc.

Martin Wolfe, Senior Data Processing Specialist

Population Services International (PSI)

Tim Manchester, Tanzania AIDS Project

Association for Voluntary Safe Contraception (AVSC)

Grace Wambwa, Technical Advisor (seen in Arusha)

International Training Program in Health (INTRAH)

Jedida Wachira, INTRAH Deputy Regional Director

Naomi Goko, Resident Advisor

Christian Medical Board of Tanzania (CMBT)

Dr. Haule

Dr. Mahimbo

Marie Stopes International Clinic

Dr. Wikedzi

Lindy Tackill

Tanzania Women's Organization (UWT)

Ms. Gladness Mziray, MP, Executive Secretary

MEWATA

Dr. S. Massawe, Chairlady

Twende na Wakati Radio Programme

Ms. D. Mwenda, Director

Arusha

Regional Health Office

Dr. N. Eseko, Regional Medical Officer
Ms. L. Msoffe, Regional MCH Coordinator
Mrs. M. Rutahiwa, Assistant Regional MCH Coordinator

Seventh Day Adventist Medical

Mr. E. Wambura, Deputy Manager, Service Delivery
Mr. E.J. Tenga, Area Project Officer
Ms. Mshana, Nurse Midwife, SDA Model Clinic
Ms. Chacha, Nurse Midwife, CBD Supervisor
Mrs. Mujungu, Nurse Midwife In Charge, Njiro SDA Clinic

Ngaranaro Dispensary

Ms. L. Matowo, FP Nurse
Ms. Maimu, Clinical Officer

Kaloleni Urban Health Center

Ms. Alute, Nurse In Charge
Mr. Yatera, Clinical Officer

Marie Stopes International Clinic

Mrs. Naomi Achimponda, Nursing Officer In Charge

Mt. Meru Hospital

Mrs. Juliet Msolla, VSC Counselor
Mrs. Genovera Anney, Public Health Nurse

Kilimanjaro/Moshi

UMATI

Ms. Pauline Tukai, Acting Area Manager
Ms. E. Andrews, Public Health Nurse
Ms. Makundi, VSC Supervisor
Mr. Franscis Salasini, Clinical Officer
Mr. S. Hokororo, UMATI Trainer

District Medical Office

Dr. Ngumuo, Deputy Medical Officer, Acting District Medical Officer, Moshi (Rural)
Ms. C. Kilewo, Acting District MCH Coordinator

Mawenzi Regional Hospital

Dr. Issa Hemedi, VSC Surgeon
Ms. A. Mjema, FP Service Provider

Regional Medical Office

Mrs. A. Mtei, Regional Nursing Officer
Mrs. E. Kaale, Acting Regional MCH Coordinator

Majengo Clinic

Mr. Mtallo, Clinical Officer

Ms. M. Mosha, Nurse Midwife Family Planning Service Provider,

Massama Health Center

Ms. Z. Msangi, Clinical Officer

Mrs. M. Swai, Senior Nurse Midwife

Mrs. F. Massawe, Public Health Nurse In Charge

Morogoro

Regional Medical Office

Dr. Ndunguru, Acting Regional Medical Officer and Medical Officer In Charge

Mrs. M. Wapalila, Regional MCH Coordinator

Ester Berege, Regional Training Team-FP

N. Masawe, Regional Health Officer

C. Mbeni, Regional Cold Chain Operator

UMATI

Dr. Mchalla, VSC Surgeon

Evodia Musiba, Nurse

Mlali Dispensary (GOT)

Mrs. Magdalena Msangi, Maternal Child Health Aide

Mgeta Health Center (GOT)

Agrippina Apolinari, Rural Medical Aide In Charge

Mariam S. Gilla, Public Health Nurse

Mrs. Temba, Maternal Child Health Aide

Fred Mamuya, UMATI CBD supervisor

Private Sector, Morogoro Town

Olele Medical Stores

Uluguru Day and Night Pharmacy

Mt. Rungwe Health Care Co.

Victoria Pharmacy

Kilombero Sugar Estate Hospital

Dr. Stephen Loina, Doctor In Charge

Dorah Natai, VSC Nurse

Mrs. E. Mushi, Supervisory Nurse

Mrs. Kitunda MCH Unit In Charge

Mang'ula Health Centre (GOT)

Anton Lyachema, Medical Aide In Charge

Fatuma Towegale, MCH Aide

St. Francis Hospital, Ifakara (Designated District Hospital)

Dr. Fred Lwilla, District Medical Officer

Mrs. Grace Lubomba, District MCH Coordinator

Private sector, Ifakara town

Duka la Madawa

St. Francis Medical Stores

Kibaoni Dispensary (GOT)

Leah Mpombo, Public Health Nurse

Selina Tayari, MCH Aide

Kesia William, MCH Aide

Frida Bernardi, MCH Aide

Lydia Tayari, Rural Medical Aide

Philister Malangalila, MCH Aide

Mwanza

Regional Medical Office

Dr. J. Marukwa, Acting Regional Medical Officer

Mrs. S. Nditi, Assistant Regional MCH Coordinator

Ms. H. Mwanaupanga, Regional Trainer/Provider

Katunguru Health Center

Mr. F. Rwitabuki, Medical Assistant

Ms. T. Fumbuka, MCH Aide

Mrs. L. Rwitahubi, Nurse Midwife

Mr. P. Mtebe, Rural Medical Aide

Seventh Day Adventist Medical

Mr. E. Msiba, Manager, CBD Program Manager

Ms. E. Malaki, Nurse Supervisor, SDA - Mwanza

UMATI

Dr. M. Nasamia, Medical Coordinator and VSC Surgeon

Mrs. J. Lucas, VSC Counsellor

Mrs. R. Manseli, VSC Counsellor

Mr. Omari, Private Sector Coordinator

Mwananchi Hospital

Dr. I.I. Mushi

Bank of Tanzania Clinic

Dr. F.M. Lukinda, Medical Officer

Ms. S. Magesa, Nurse Midwife

Mwanza Urban Medical

Ms. A. Festo, MCH Coordinator

United Nations High Commission for Refugees

Mrs. Juarez, Assistant Program Representative

APPENDIX C

LIST OF DOCUMENTS REVIEWED

1. Report on Study to Quantify the Government Contribution to Family Planning, January 3 - April 8, 1994 by Dr. Anna Kessy & Josselyn Neukom
2. Tanzania Family Planning Unit Management Needs Assessment - by Allen Brimmer, Ray Kirkland & Mark Okunnu, 21 December 1993
3. Tanzania Assessment Program for Permanent and Long Term Contraception - FPU/UMATI/AVSC/USAID, November 1-12, 1993
4. Monitoring & Evaluation Systems for USAID/T Family Planning Services Support (FPSS) Project - EVALUATION Project, by Naomi Rutenberg & Bob Magnani, March 1993 (Draft)
5. Basic Training Skills Curriculum Volume I - MOH/FPU, INTRAH, April, 1993
6. Comprehensive Family Planning Clinical Skills Curriculum - by INTRAH/MOH, July 1993 Revision
7. The Five Year Strategy for Family Planning Training 1994-1999, Final Draft, July 1994, MOH & INTRAH
8. Ministry of Health - National Family Planning Programme - Plan of Operation 1989-1993 by Ministry of Health & Social Welfare, January 1989
9. Audit Report of the Family Planning Unit for the Period January 1, 1992-June 30, 1993, - by the Controller and Auditor General, Tanzania (Undated)
10. Trip Report by Dana Vogel & Michael Mushi, HPO/USAID/T to Arusha, December 8-15, 1991
11. Trip Report by Dana Vogel & Michael Mushi, HPO/USAID/T to Mwanza & Shinyanga Regions, March 20-27, 1994
12. Trip Report - by Sharon Rudy, JHU/PCS, Finalizing NFPP Strategic Plan; Writing Midterm Assessment for USAID FPSS Project; Monitoring & Final Evaluation Activities for Family Planning Communication Project, May 30-June 19, 1994
13. An Annotated Bibliography of: Information on Adolescent Sexuality in Dar es Salaam - by Mpangile G.S. & Mbunda W.M. for UMATI, December 1992
14. United Republic of Tanzania - National Population Policy, President's Office, The Planning Commission, March 1992
15. Cable drafted by Dana Vogel to A. Brimmer on Summary Findings from Assessment of INTRAH Tanzania Training Project, July 14, 1994
16. Attitudes & Beliefs Regarding Child Spacing: Focus Group Discussion with Men & Women from 6 Regions of Tanzania - MOH/HED & JHU/PCS, December 1991

17. Tanzania Baseline Audience Survey, 1991 - by Mr. W. Mbunda; Dr. M. Jato, Dr. Y. Mi Kim, Dr. T. Valette & Ms. C. Lettenmaier, UMATI, JHU/PCS, (Undated)
18. Family Planning Services Environment in Tanzania: A Report based on the 1991 & 1994 DHS Service Availability Modules - by S. Ngallaba, P. Bardsley, D. Guilkey & R. Riphahn, EVALUATION Project, August 12, 1994
19. A Study of Couple's Knowledge Attitude & Practice on Contraception in Mkuu, Mashati & Mengwe Divisions, Rombo District, Tanzania - By M. Mushi, October 1990 - AMREF, Nairobi, Kenya
20. Tanzania Demographic & Health Survey 1991/1992 - by Silvester Ngallaba, S. H. Kapiga, I. Ruyobya & J.T. Boerma, Bureau of Statistics Dar es Salaam, and Macro International, Columbia, Maryland, June 1993
21. Tanzania Baseline Clinic Study 1992 - by C.N.B. Kihinga, MOH/HED & JHU/PCS, May 1993
22. USAID - Tanzania Family Planning Pre-service Education Assessment - by A. Brimmer & S. Ross, September 4, 1992
23. USAID/Tanzania - Memo from Dana Vogel to the Executive Officer on Vehicle Procurement dated December 16, 1993
24. Baseline Family Planning IEC KAP Survey, Preliminary Results - by Walter Mbunda & Miriam Jato, UMATI and JHU/PCS, presented in a workshop, June 22-26, 1992
25. Consultants' Report on Tanzania National CBD Protocol & Supervision Manuals Development Process - by E.B. Kalaule & P. Ochola, Pathfinder, May-June, 1994
26. Tanzania CBD Programme - Supervision Manual - by E.B. Kalaule, July 1994 (draft) Pathfinder
27. Tanzania CBD Programme - Protocol Manual - by E.B. Kalaule, July 1994 (draft) Pathfinder
28. Pathfinder - Assessment of Pathfinder Supported CBD Projects in Tanzania - Dar es Salaam, May 5-20, 1994 (no author)
29. Pathfinder - Expansion of Family Planning in Tanzania: Strategy for a National CBD Program: Submitted to MOH by Pathfinder International, May 28, 1993
30. Family Planning Association of Tanzania Annual Report, 1993 - by UMATI, March, 1993
31. Family Planning Association of Tanzania, Revised Work Programme Budget 1993 - December 1992
32. Family Planning Association of Tanzania, 1994 Half Year Report, March 1994
33. Family Planning Association of Tanzania, Work Program Budget 1994, October 1993

34. Family Planning Association of Tanzania, Work Program Budget 1993, December 1992
35. Family Planning Association of Tanzania, Strategic Plan (Revised) 1992-1996
36. Family Planning Services Support Project No. 621-0173, Project Paper, August 20, 1990 & Technical Analyses (Project Paper Report - Logistics & Management Information Systems),
37. Tanzania AIDS Project No. 621-0177, Project Paper & Annexes H1 through H9
38. Factors Associated with Induced Abortion in Public Hospitals in Dar es Salaam, Tanzania, by Mpangile, G.S.: Leshabari, M.T.: Kihwele, D.J.: October 1992
39. Work-based Family Planning & AIDS Services a Field Test of Two Strategies for Serving factory workers in Dar es Salaam, August 1993 - by Population Council
40. Quality Management for Family Planning Services - by J. Dwyer, & T. Jezowski (AVSC), June 28, 1994 (paper)
41. Supervision & Quality Improvement Workshop for Clinic Based Services, August 7-12, 1994, Arusha, Tanzania - by MOH/FPU, UMATI, USAID & AVSC (paper)
42. Mid-Project Assessment: Family Planning Communication Project, JHU/PCS & HED 1990-1994, August 1994
43. Trip-Report: Dar es Salaam May 17-21, 1994, Susan Settergren - RAPID IV, June 1994
44. National Family Planning Program (NFPP) Strategic Plan, 1994-1999 - by MOH/FPU & SEATS, 1994 (Draft)
45. Miriam Jato, Maurice Mbango: Family Planning Communication Effectiveness Sparks in Dar es Salaam, Kisarawe and Mwanga 1994, JHU/PCS September 1994
46. Tanzania MOH/USAID - Family Planning, January 1992 - February 1995, Draft revised August 26, 1994, (no author or publisher)
47. Family Planning Communication Project, 1991, Childspacing is part of our tradition: the results of focus group discussions with men and women from nine Tanzanian communities. Draft Report
48. Fundikira, S.R., 1985, Sexuality, fertility and contraception: knowledge and attitudes among secondary school girls in Dar es Salaam. Thesis, Public Health, UDSM
49. Kapiga, S., et al., 1992, Reproductive knowledge and contraceptive awareness and practice among secondary school pupils in Bagamoyo and Dar es Salaam. Ms.
50. Leshabari, M., 1988, Factors influencing school-adolescent fertility behavior in Dar es Salaam, Tanzania. DSc thesis, Johns Hopkins

51. Muhondwa, E., 1991, Review of KABP findings: preliminary report. Presented at workshop, Kibaha.
52. Muhondwa, E., et al., 1991, The joint KABP/PR surveys: preliminary communication. Unpublished Ms.
53. Omari, C.K. (1989a), "Some Socio-Cultural Aspects in Social Communication: The Climate in Communication Process" Paper presented at a Workshop on Social Communication Curriculum Development Arusha, November 6-15, 1989
54. Omari, C.K. (1989b), Socio-Cultural Factors in Modern Family Planning Methods in Tanzania, New York: The Melen Press
55. Safeguard the Future, UNFPA Tanzania, Tanzania Publishing Limited, Dar es Salaam, 1994
56. National Family Programme Annual Report 1992, Family Planning Unit, Dar es Salaam
57. Family Planning Programme Annual Report 1993, Family Planning Unit, Dar es Salaam
58. National Family Planning Programme Progress Report, April-June 1994, Ministry of Health, Dar es Salaam
59. Tanzania: The Family Planning Situation Analysis Study, Ministry of Health Dar es Salaam, Tanzania and Population Council, Nairobi, Kenya, 1992
60. National Family Planning Programme Strategic Plan, July 1994-June 1999 (Final Draft)
61. National Family Planning Policy Guidelines and Standards for Family Planning Service Delivery Training, MOH and INTRAH, August, 1992
62. Tanzania Assessment, Programme for Permanent and Long Term Contraception, Ministry of Health/Family Planning Unit, UMATI, Association for Voluntary Surgical Contraception and USAID, November 1-12, 1993
63. Tanzania Ministry of Health/INTRAH Family Planning Project Evaluation Report, Dar es Salaam, July 1994 (2nd Draft) (undated).
64. Population and Development Course for Regional Medical Officers, 31 May,-25 June 1993, Institute of Development Management, Mzumbe, Tanzania
65. The Role of SEATS Project, June 1991-June 1994, JSI/SEATS Harare, Zimbabwe (Undated)
66. USAID/Tanzania Country Programme Strategic Plan 1992-1997, August 1992
67. FM Mburu, UPDATE on: The Family Planning Services Support Project: Tanzania Socio-economic Environment, Status and Prospects for Family Planning Services, USAID/Tanzania, August, 1994
68. USAID/Tanzania - Request for Supplemental Funds for Population/Family Planning Activities

69. USAID/Tanzania - Dana Vogel, The Institutional Framework of the Family Planning Services Support Project (FPSS) Comments and Observations, September 12, 1994
70. USAID/Tanzania - Trip Report: Visit to Kilimanjaro FP Activities, August 7-13, 1994, FM Mburu
71. USAID/Tanzania - Trip Report: Mwanza Region, July 14-21, 1993, FM Mburu
72. MOH - National Policy Guidelines and Standards for Family Planning Service Delivery and Training, September 1991
73. Tanzania Demographic & Health Survey 1991/92 Summary Report, Bureau of Statistics, Dar es Salaam, June, 1993
74. Tanzania: Population Health & Nutrition Sector Review, October 1989, World Bank Report, Population & Human Resources Operations Division, Southern Africa Department
75. Tanzania: Role of Government, Public Expenditure Review Volume 1, World Bank Main Report, February 1994, Country Operations Division, East Africa Department
76. Donor Assistance to the Health & Population Sector in Tanzania, by Bente Ejlsing Svantesson, Sponsored by DANIDA, 1994
77. Tanzania and UNICEF - Country Programme 1992-1996, Master Plan of Operation, May 1992, Dar es Salaam.
78. UNFPA: Proposed Projects and Programs - Recommendations by the Executive Director, Assistance to the Government of the United Republic of Tanzania support for a Comprehensive Population Programme.
79. ODA Family Planning Services Supplies Project: Supplies of Depo-Provera.
80. United Republic of Tanzania: Third Country Programme 1992-1996 Mid-term Review, Background Brief, UNFPA, Dar es Salaam, July 1994
81. Development of National Guidelines for District Primary Health Care Transport, Crown Agents, Ministry of Health, GOT, Febr 1994.
82. Contraceptive Procurement Tables, FPLM, April 1994.
83. FPLM Trip Report, Papworth, D., Perry, S., Thompson H. FPLM, May 1994.
84. FPLM Trip Report, Halpert P., FPLM, September 1993.
85. NEWVERN printout, Tanzania, 1989 - September 1994.
86. FPLM Trip Report, Perry S. and Felling B., March 1993.
87. FPLM Trip Report, Perry S., August 1992.
88. FPLM Trip Report, Perry S. and Atkinson B., April 1992

89. National AIDS Control Programme, HIV/AIDS/STD, Surveillance Report No. 7, December 1992, MOH/FPN
90. Rukonge, A.D., Family Planning Clinic Based Suspension and Quality Improvement Workshop, presented in Arusha, August 7-12, 1994
91. Hunter, S., National STD Planning Workshop, March 1-4, 1994

APPENDIX D

COMPARING FAMILY PLANNING FACTORS 1991/2 AND 1994

CHANGES IN SELECTED ASPECTS OF SERVICE DELIVERY AND POPULATION-BASED OUTCOME MEASURES

1. Facility-Based Measures

Presence of trained personnel at service delivery points (SDPs)

Two indicators of staff preparedness to provide family planning services were included in the Service Availability Modules (SAM) conducted in connection with the 1991/2 Tanzania Demographic and Health Survey (TDHS) and the 1994 Tanzania Knowledge, Attitudes, and Practices Survey (TKAPS): (1) presence of staff trained in family planning and (2) presence of staff trained in IUD insertions (see Table 2.3). No clear trends are discernable on either indicator.

Percent of SDPs offering selected contraceptive methods

Sizable increases in the proportions of facilities offering injections, IUDs, and foam are observed in comparing the 1994 with the 1991/2 SAM data, particularly at health centers and dispensaries (Table 2.3). The proportion of facilities offering oral contraceptives and condoms was (theoretically, at least) already over 90 percent in 1991/2, and approached 100 percent by 1994.

Availability of contraceptives at SDPs

Two measures of contraceptive logistics systems functioning were obtained in the SAMs: (1) percentage of facilities with selected methods in stock (as determined by physical verification) and (2) percentage of facilities that had to pick up supplies (instead of supplies reaching them through the distribution system). Except for condoms (which appear to have been relatively well-stocked in 1991), significant increases in methods that were "in-stock" were observed (Table 2.3). Small, but consistent, declines in the proportion of facilities that had to pick up their own supplies from distribution points were also observed at all facility levels. These results point to a marked improvement in contraceptive distribution system functioning and in method availability at service delivery points.

Service volume

Evidence of increased service volume is available from several sources. SAM data show a 49 percent increase in mean numbers of new acceptors per month and a 40 percent increase in resupply clients at hospitals between 1991 and 1994 (Table 2.3). More modest increases are observed for health centers and dispensaries. Monthly time-series data from three service delivery points (in Dar es Salaam, Kisarawe, and Mwanga) visited in connection with the KAP surveys conducted in connection with the Family Planning Communication Project (FPCP) indicate an upward (albeit irregular) trend in client volume between 1991 and 1994 (Figure 2.1). Finally, MOH/FPU service statistics show an increase in annual numbers of first attendances of 46 percent between 1992 and 1993 (Table 2.5). Although each of the three data sources may be deficient in certain respects, the observation of common trends in all three strongly supports the conclusion that service volume has increased markedly during

the first half of the project period. The SAM data suggest, however, that the bulk of the increased family planning service volume during the 1991-94 period occurred at hospitals as opposed to health centers and dispensaries, where the large majority of health service contacts take place.

2. Population-Based Measures

Awareness of contraceptive methods

Evidence of changes awareness of contraceptive methods is available from both the FPCP KAP and the TDHS-TKAPS survey series. Although the surveys are not directly comparable,¹ comparisons across each survey series indicate that awareness of modern contraceptives had grown between 1991 and 1994. The FPCP surveys indicate that in 1994 nearly 8 of 10 respondents of both sexes could name at least one modern contraceptive method without prompting (Table 2.4). With prompting, knowledge of at least one modern contraceptive method was nearly universal among female respondents. These estimates are consistent with national estimates from the 1994 TKAPS (Table 2.6). The TKAPS data also indicate that sizable regional differences in contraceptive awareness among currently married women persist, with awareness levels being considerably higher in Dar es Salaam than in Mwanza.

Exposure to family planning messages

Comparison of TDHS and TKAPS data suggests that NFPP mass media efforts have been extremely successful. Nationally, the proportion of currently married women who had not heard a family planning message on either radio or TV fell from 76 to 39 percent, and was below 10 percent in Dar es Salaam in 1994.

Family planning-related beliefs, rumors, and misperceptions

Data from the FPCP KAP surveys suggest that, due at least in part to NFPP I-E-C efforts, negative rumors and misperceptions regarding family planning have begun to lose credibility in the general population. A smaller proportion of respondents in 1994 than in 1991 believed that (a) family planning (FP) makes women promiscuous, (b) FP causes conflict among spouses, (c) FP is against God's will, (d) and FP makes men jealous (Table 2.4). Interestingly, belief regimes of men seem to have changed to a greater extent than those of women during this period.

Contraceptive use

Nationally, all-method contraceptive prevalence increased from 10 to 24 percent between 1991 and 1994, and modern method prevalence rose from 7 to 16 percent (Table 2.6). Increases in modern method use were spread across methods, with the most sizable

¹ Due to time limitations, it was not possible to process all of the data from the 1994 surveys. The FPCP KAP surveys cover three regions (Dar es Salaam, Kisarawe, and Mwanza), while estimates from the TKAP data are for Dar es Salaam and Mwanza, with preliminary national estimate obtained by inflating data from the survey clusters that had been processed by the time of the MTR. Conclusions as to changes at the population level should thus be viewed as tentative until the full data sets have been analyzed. Note also that the FPCP surveys are not probability samples, and thus their generalizability is uncertain.

gains (in absolute terms) being observed for pills and injection. During this period, modern method prevalence doubled in Dar es Salaam, and rose from 2 to 7 percent in Mwanza. In Dar es Salaam, prevalence for oral contraceptives reached 10 percent in 1994.

Method mix and source of services/supply

Although the sample size for the TKAPS is modest and conclusions should thus be viewed as tentative, the available evidence suggests a growing diversification of the method mix (Table 2.6). Nationally, use of oral contraceptives as a percentage of total modern method use fell from 52 to 37 percent, while use of injection rose from 6 to 24 percent of total modern method use.

Demand for children

Relatively small, and not statistically significant, changes in desire/demand for children at the national level are observed in comparing the TDHS and TKAPS data (Table 2.6).

Demand and unmet need for family planning

More or less as was anticipated in the design of the FPSS Project, strengthening of family planning service delivery resulted in the "soaking-up" of a share of the unmet need for family planning that existed at the outset of the project (Table 2.6). Nationally, unmet need (total - for limiting and spacing combined) fell from 30 to 28 percent. More substantial declines in total unmet need were observed in both Dar es Salaam (from 34 to 23 percent) and Mwanza (from 27 to 21 percent).

The relatively modest decline in unmet need is explained in part by a substantial increase in total demand for family planning services during the early part of the project period (from 41 to 52 percent nationally - a 22 percent increase). Demand for limiting rose from 17 to 22 percent during this period, while demand for spacing increased from 24 to 30 percent. Both total demand and demand for limiting in Dar es Salaam exceeded the national average in 1994, while Mwanza fell substantially below the national average on both components of demand, but most notably with regard to demand for limiting.

As of mid 1994, family planning services in Tanzania were satisfying 46 percent of total demand nationally (51 percent of demand for limiting and 43 of demand for spacing). The observed differences between Dar es Salaam and Mwanza (58 and 35 percent, respectively) suggest that progress in satisfying demand to date has been uneven. Worthy of note is the fact that although the FPSS Project has a special long-term/permanent methods component, both total demand and unmet need for spacing exceeded that for limiting as of mid-1994.

Contraceptive intentions

Although intentions stated in household surveys do not necessarily reflect future behavior, evidence from the TDHS and TKAPS surveys suggest growing future demand for family planning services (Table 2.6). Nationally, the proportion of currently married women not currently using a contraceptive method who stated an intention to begin use within 12 months of the survey nearly doubled (from 19 to 36 percent), while the proportion who said that they did not intend to contracept at any time in the future fell nearly 50 percent (from 60 to 34 percent).

APPENDIX E

GRAPH: Service and Method Availability, IUDs, 1991 and 1994, TDHS and TKAPS.

GRAPH: Service Volume by Facility Type, 1991 and 1994, TDHS and TKAPS.

GRAPH: Contraceptive Prevalence Rates, 1991 and 1994, TDHS and TKAPS.

GRAPH: Demand for Family Planning Services, 1991 and 1994, TDHS and TKAPS.

GRAPH: Contraceptive Intentions, 1991 and 1994, TDHS and TKAPS.

GRAPH: Service and Method Availability, Oral Pills, 1991 and 1994, TDHS and TKAPS.

GRAPH: Total and Unmet Demand for FP for Selected Regions, 1994, TDHS and TKAPS.

GRAPH: Method Mix, 1991 and 1994, TDHS and TKAPS.